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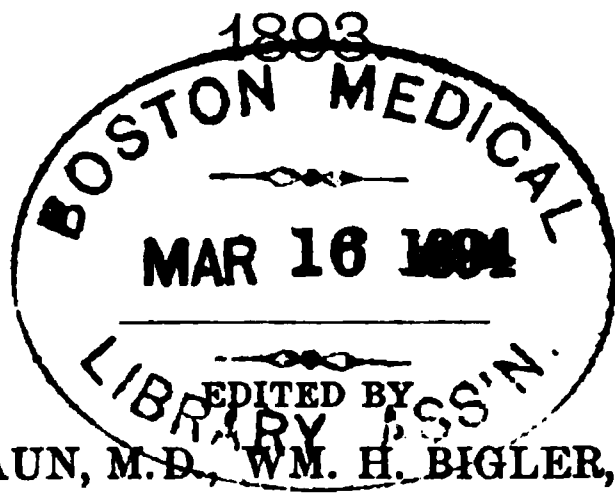
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THE
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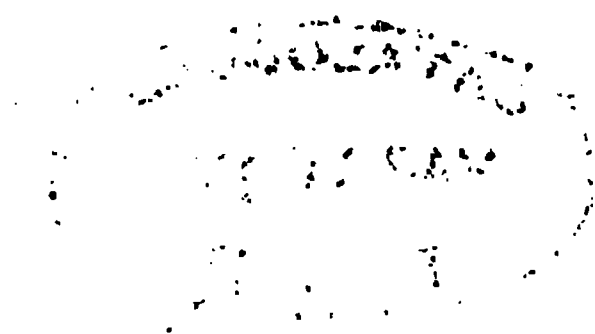
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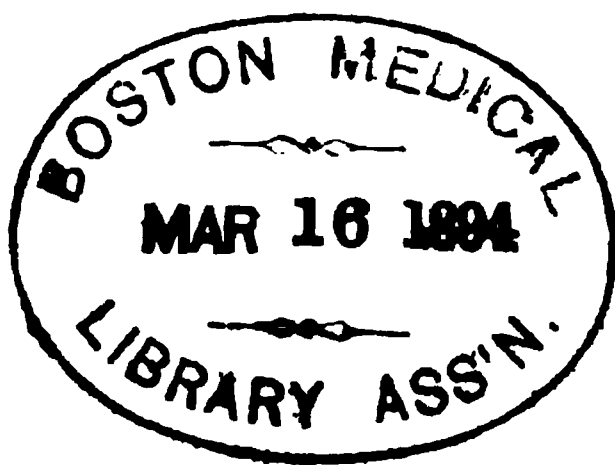
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THE HAHNEMANNIAN MONTHLY.

JANUARY, 1893.

'BLOOD IN THE URINE—DIAGNOSIS AND TREATMENT.

BY CLIFFORD MITCHELL, M.D., CHICAGO, ILL.

THE diagnosis of hæmaturia has been greatly helped by the invention of the endoscope and cystoscope. The use of these instruments has shown us that we cannot always rely on the color of the urine, its quantity and specific gravity, its reaction, presence or absence of casts, nor the shape of blood-clots as positive signs of the source of the blood. Thus, Bangs* reports seeing bright red blood in renal hæmorrhage, this color, however, formerly being held to be significant of bleeding from the bladder. I myself have seen blood from the kidneys in urine of normal specific gravity, so that we cannot rely on lowered gravity as always present in renal hæmorrhages.

It is quite possible, also, that hæmorrhage from the urethra or kidneys might take place at a time when the urine was alkaline from fixed alkali, as in cases of flatulent dyspepsia, or, as Ultzmann says, that a profuse hæmorrhage might, by the natural alkalinity of the blood, overcome the natural acidity of the urine. Yet it has been held that if the reaction is alkaline, the blood comes from the bladder.

Again, the presence of pencil-shaped clots has been thought to be

* *Med. Record*, November 5, 1892.

almost sure proof of blood from the ureters or kidneys, but I have seen such clots in a case where the endoscope showed the bleeding to be in the membranous urethra.

It has been said, also, that if tube casts are found in the urine, together with blood, the latter is renal in origin. So it is in many cases, but I have repeatedly found pale hyaline casts in the pyurias from catarrh of the vesical neck, the casts due, I suppose, to accompanying congestion of the kidney. The urine, in some of these cases, contained blood as well as pus, both coming from the prostatic urethra.

In the following article is suggested a new method of differential diagnosis in hæmaturia, based on observation from cases in practice. I have combined the information derived from the use of the endoscope with a study of the character of the urine in cases where the source of the bleeding was positively known either before or after death.

A. The urine contains blood, but in other respects is normal. On standing in the bottle, the blood separates completely, whilst clear, normal urine floats above it. The bleeding is probably somewhere in the course of the urethra, especially in young male patients. The use of the sound or endoscope will provoke more or less discharge of blood, and the endoscope will tell from what portion of the urethra the blood comes.

Bleeding at the end of micturition has been noticed in cases where the blood was from the *anterior* urethra, as well also as frequent urgings to urinate, so that these symptoms cannot always be relied upon as proof positive of a posterior urethral hæmorrhage. If the blood can be squeezed out at the meatus between micturitions, there is bleeding from the anterior urethra. Cases in which but a few drops of blood are passed at the end of micturition, together with pyuria, albuminuria, signs of renal congestion, and other symptoms of posterior urethritis, will not be considered in this paper.

B. The urine contains blood, and in other respects is normal or abnormal, but the blood does not separate completely, remaining more or less intimately mixed with the urine. The bleeding is from the ureters, bladder or kidneys, and the sound or endoscope in the urethra does not excite hæmorrhage.

1. From the bladder, if mixed with stringy pus in alkaline, foetid urine, no hæmorrhage being excited by the sound in the urethra.

2. From the bladder also, even when no pus and urine possibly acid, if no bleeding is provoked by sound in the urethra, but by

exploration of the bladder; or if, after washing out bladder, pressure over the bladder excites bleeding, and washings are tinged with blood, *while, at the same time*, injection into the bladder of solution of potassium iodide results in the detection of iodine in the sputum.* It is not enough that the bladder-washings are tinged with blood. Bangs reports a cases of malarial hæmaturia in which the washings and drainings were always tinged with blood, while cystoscopic examination showed a healthy bladder but blood trickling from the ureter.

He says: "The fallacy in it, against which we must carefully guard, is that blood may trickle into the bladder from the ureters, coagulate, and be delivered at the end of the catheterization, simulating the bleeding from a vesical neoplasm. I have been led to multiply the washings, and to add the device of pressure over each kidney and ureter in turn between the washings. Thus: The catheter is passed, and the last portion of urine gathered in a separate glass. The color and characteristics of this small quantity are noted, and the glass numbered and set aside for microscopic examination. The bladder is then thoroughly washed, emptied and the last few drops of the fluid separated in another glass. The bladder is again washed, emptied and the catheter allowed to remain a few moments, while deep, bimanual pressure is made over (for example) the right kidney and along the course of the right ureter. The fluid, which escapes slowly, and often only in drops, is also gathered in a separate glass and set apart for microscopic examination. The bladder is again washed, and the manœuvre repeated with the left kidney and ureter. If the small amount of fluid which is gathered under these circumstances is tinged with blood, the strong probability is that it comes from the kidney, and subsequent microscopic examination of the fluid may convert this probability into certainty."

3. From the kidney parenchyma, if casts containing blood cells or composed of blood cells can be found.

4. From the kidney parenchyma, even if no blood-casts can be found, but granular, fatty or waxy casts are present, while at the same time when the patient does not drink freely at night the quantity of night urine approximates or exceeds the day.

5. From the parenchyma of the kidney, even when only hyaline casts or perhaps no casts at all can be found, if the quantity of night urine approximates or exceeds the day's, with urea 5 to 6 grains to

* See author's *Diseases of the Kidneys*, 2d ed., p. 224. Keener, Chicago.

the ounce or less, ratio of urea to phosphoric acid increased, patient losing flesh and strength and showing other symptoms of contracting kidneys. (Not necessarily from parenchyma of kidney if only pale hyaline casts are found without the other conditions above-mentioned. Hyaline casts are occasionally found in catarrh of the vesical neck with hæmorrhage, and due to accompanying congestion of the kidneys.)

6. From the pelvis of the kidney by exclusion of urethral, bladder and kidney-parenchyma hæmorrhage: (a) Due to stone in the kidney-pelvis, if it disappears on prolonged rest, and together with the pain is aggravated by jolting (though not always immediately) with but slight albuminuria. Urine often contains but a faint tinge of blood on top of pus and crystals; (b) due to tubercular disease if the blood is present during repose with pus and much *débris* and considerable albumin, with other signs of tuberculosis of genito-urinary apparatus, and by exclusion of stone and cancer; (c) due to cancer, if the blood is not only present during repose, but there is in the same day an alternation of clear and bloody urine, with little or no pus. Blood much more profuse at some times than at others and without apparent cause. Persistent dull, heavy pain, sometimes sharp, in one loin or the other, aggravated by position, possibly ameliorated by rubbing. Later, tumor in the loin, cachexia, etc.

CASES FROM PRACTICE.

CASE I.—F. E. P., æt. 25 years, single; without the use of the endoscope this case was puzzling; the patient had pencil-shaped clots in the urine and complained of pain down the course of the ureter. Inference was that the blood was from the kidney and the pain was caused by passage of clots through ureters. On closer questioning it was revealed that pain was not *down* the course of the ureter at all but *up* from the neck of the bladder. No special symptoms except hæmaturia and pain on passing bloody urine. Urine contained at times a few pale hyaline casts, but settled clear above the blood sediment, and in general showed nothing abnormal except the blood. Examination with the endoscope by Dr. C. D. Rich showed erosions and easily bleeding areas in the *membranous and prostatic urethra*.

CASE II.—Mr. C., æt. 40. Day and night urine about alike in quantity, and total twenty-four hours' urine diminished. Specific gravity, 1022. Reaction acid. Urine does not settle entirely clear from the blood, but is more or less intimately mixed. Blood casts

are present. Albumin, trace only. Sediment contains, in addition to blood and blood casts, uric acid crystals. No pus. Patient feels well enough except for pain in the region of the left kidney, sometimes down the ureters and in the left hypochondriac region. Pain is persistent, aggravated by certain positions, helped by rubbing. The bleeding is much more profuse at times than at others, with several weeks or months interval. Profuse hæmorrhages lasted several days. Autopsy showed *cancer of the kidney*.

N. B.—This case teaches that the specific gravity does not always show the source of the blood, and that pain down the course of the ureter does not always mean stone. It was probably due to the passage of clots. The finding of blood-casts was due probably to a coincident nephritis or congestion, which, however, did not progress as rapidly as the malignant disease. There were uric acid crystals in the urine, but absence of pus, the profuse, long-lasting hæmorrhages at intervals, unconnected with motion, and persistent pain, taken altogether would rule out stone. Absence of pus and *débris* with little albumin, and no signs of tuberculosis, would eliminate tubercle. The specific gravity and quality of the urine would not suggest contracting kidney. Age of the patient, absence of dropsy, etc., would be against acute or subacute nephritis.

CASE III.—Mr. B., æt. 25, no history obtainable, and no symptoms except hæmaturia, which was as noticeable after rest as after exercise. Blood settles completely, with clear acid urine floating above it. Albumin trace, corresponding to blood. No casts. A few pus-cells. Made diagnosis of urethral hæmorrhage. Endoscope showed the source of the blood to be the *prostatic urethra*.

Since case 3, I have had one or two other cases similar in character. When uric acid crystals, and more or less pus, are found together with the blood, as sometimes occurs, our thoughts revert to stone in the kidney, but the usual well-known symptoms of posterior urethritis are a help in fixing the locality whence the blood is derived. *But presence of these symptoms may be denied* by patients, and then our reliance is to be placed on the endoscope.

DIAGNOSTIC SUMMARY.

1. In the diagnosis of urethral hæmorrhages, the settling of the blood leaving clear urine above it, together with endoscopic examination, is what we should rely upon.

2. Ruling out urethral hæmorrhage, that the blood is from the bladder may be decided on by the usual signs of cystitis, or by

pressure after washing out, together with the resorption test, or by use of the cystoscope, if possible.

3. Blood from the kidneys is easily recognized if blood-casts can be found. If not, the approximation of night urine to day is an important point, especially if casts, even not blood casts, are numerous, or, if not, poor quality of the urine is noticed, especially if with the usual symptoms of contracting kidney.

4. Blood from the renal pelvis must be inferred by exclusion, and in the differential diagnosis between stone, tubercle, and cancer, aggravation, without seeming cause, of the profuse and long lasting hæmorrhage, at intervals of weeks or months, or recurrence of clear and bloody urine, in one and the same day, without much pus or *débris* and without much albumin, are in favor of cancer. Additional evidence of the presence of cancer is to be had in the presence of pencil-like clots, persisting pains, and tumor usually in left renal region. But pencil-like clots alone are not enough to establish the diagnosis. Ruling out cancer, the diagnosis between stone and tubercle is usually not difficult, since the hæmaturia of renal calculus is rarely profuse, is more or less intermittent, and dependent on motion, whilst the urine itself, though containing pus, is free from *débris*, and with usually but little albumin.

5. In doubtful cases, where there are no bladder symptoms, but yet bladder-washings contain blood, recourse may be had to the device of Bangs, namely, pressure over each kidney and ureter in turn.

6. In obscure hæmaturias, bear in mind always the possibility of malaria, and note effect of treatment for the same; malarial hæmaturia (renal blood) somewhat resembles the bleeding in cancerous cases, but absence of pain, and the long continuation (often six or eight years) serve to distinguish.

(*To be continued.*)

PROVING OF HAMAMELIS.—Dr. John H. Clarke administered hamamelis to a patient suffering from varicose limbs. It apparently produced the following symptoms:

Marked loss of appetite, continuing all the time.

The day after commencing the medicine she had:

Pain all around lower abdomen.

Dreadful aching, rheumatic pain at the top of the left shoulder and under the right shoulder-blade; also right side of the chest under the arm.

There was a dull stupid feeling in the head.

The pains were worse during the day, worse when at rest, but she did not have them at all during the night.—*Homœopathic World*, October, 1892.

ARBORIVITAL MEDICINE.

BEING AN INQUIRY INTO THE CURATIVE POWERS OF SOME OF
OUR COMMON FIELD AND GARDEN PLANTS, JUDGED
OF BY THE DISEASES OF THE EAR.

And the leaves of the tree were for the healing of the nations.—Rev. xxii., v. 2.

BY ROBERT T. COOPER, M.A., M.D., LONDON,

Physician Diseases of the Ear, London Homœopathic Hospital.

THE title chosen for this paper is one that requires explanation. The term arborivital is given for two reasons: firstly, from a profound conviction that in vegetation, in living or rather growing vegetation, are to be found forces sufficient to cope with all diseases; or, to express the same truth in wider or more general language, to vegetation, king of which is the Tree, directed by the hand of man, are we to look for the removal of all kinds of calamity amongst animal life, king of which is Man, agreeably with the Biblical dictum; the tree of the field is man's life, Deut. xx., v. 19. And, secondly, because the term arborivital implies to some extent the existence of a living force—so to speak—in plants, the laws of which in its behavior upon human disease tissue it is my object to ascertain, and which I aim at ascertaining as far as possible apart from any medicinal force that is fairly attributable to the irritating particles of which the plant is composed, or to the existence of a chemical active principle, or to a force engendered by the well-known processes of succussion or trituration.

The assumption upon which I start is that we must seek to utilize the *growth-force* of plants, as being a force which if more studied and more sought after in the preparation of herbal remedies will inevitably improve our therapeutic system. Of course my sphere of practice leads me to deal principally with the diseases of the ear, and it is from this class of diseases that most of the experiences about to be related are taken; and hence the title of this paper. It is then a necessity that suggests the sub-clause in the title of the paper, "*Judged of by the Diseases of the Ear.*" But even if not prompted by necessity to insert such a clause in the title, it would I consider be extremely desirable that an investigation like this should be undertaken in this special department of Medicine; and for three reasons, the first being that the chronic diseases of the ear are by all systems of medicine

difficult of cure and supply the severest test possible for a therapeutic scheme; the second that it is almost impossible to obtain all the symptoms from an ear patient both because the latter so frequently is unable to hear, or if able to converse, so disinclined to afford information as to matters unconnected with his ears,—and therefore these cases are specially out of reach by symptomatology; and the third, that symptoms referable to ear diseases are circumscribed more than those of any other organ. Ear diseases are in fact capable of being included in two great groups, fairly recognizable by the symptoms: Deafness and tinnitus, to which may be added, but only as accompaniments of these, the discharges of the ear; consequently ear diseases do not furnish the varied and complicated collection of symptoms that the other organs of the body do, there being therefore more probability of being able to simplify at all events their symptomatic treatment. Where easy communication cannot be kept up between the patient and the medical attendant, and where the former is both from necessity and education averse to affording the information strict symptomatology requires, it is hard to see how treatment by the totality of the symptoms can lead to any very successful issue in aural practice. The ordinary aurist never inquires into the state of health of his patient, and so the public is educated into withholding information; in fact ear patients have often refused to consult me a second time from no other reason than that of my having interrogated them as to their general health. But if it be objected that indeed it is the symptoms by which we are guided in the special prescriptions hereinafter given, we are not inclined to dispute the matter; the truth will lie very much in the definition of the word symptom. However I have no particular reason for enumerating the many objections to which a scheme like this may give rise: every stage of our proceeding I am well aware bristles with possible theoretical objections. With these I am in no way concerned, so long as the facts elicited are desirable ones; enough for me if I can really improve the treatment of ear cases, and at the same time add to the knowledge of the actions of the common plant with which we are surrounded. To me it is nothing short of a disgrace that we have as yet nothing better to consult than the old herbal works, the principal one of which was published in 1652 (this I believe being the date of Culpepper's first edition), in order to obtain some information as to the curative influences that reside in our common herbs. It is no reply that homœopathy has shed a full and scientific light upon many of these; this is so certainly, but has it done anything bordering upon its duty,

seeing that it is far and away the most scientific system of medicine known, and has been established upon correct scientific principles by its founder? I leave the question unanswered.

Starting as I do with the assumption that growth-force is *the* force whose laws should be determined, it will follow that the effects of every plant upon diseased states ought to be investigated quite independently of anything at present known of them. In investigating the actions of various plants we have hitherto had before us three different ideas: first, that the more poisonous a plant is the more applicable it is in disease; this is really tantamount to the phrase so often met with in allopathic works that such and such a plant has no active medicinal properties; and to a large extent at least this is the idea also underlying the statement of homœopaths that the more varied the pathogenetic symptoms the more varied the curative sphere. The ideas are not, I admit, quite the same, seeing that we depended upon succussion to develop both the pathogenetic and curative actions of plants. Whether we regard these ideas as two, or as one, matters not to me; both are shut out from our scheme of investigation, which assumes an all powerful growth-force in every plant and endeavors to discover its laws. Homœopathy, I admit, introduced such remedies as lycopodium which in no way could be considered poisonous; but admittedly lycopodium owes its efficacy to the trituration and succussion to which it is subjected, so that it and others like it come under the category of dried substances. An arborivital preparation of lycopodium would be from the stem, leaves and leaf-stalk of the growing fern. The idea has prevailed that all substances must be proved on the healthy before being administered to the sick. This certainly is a strong position to attack, and I do attack it; but only so far as we are unduly deterred by it from investigation. Before everything else the scientific physician ought to be careful not to profess more than he can perform. As in religion it is possible to have the form of godliness and yet to deny the power of it, so in medicine it is possible to profess true scientific principles and yet be injuriously hindered by them. It is a true scientific principle, I consider, that drugs ought to be proved before being administered to the sick, but it is a hindrance to insist that in the absence of a proving no drug should on any account be given. Let us before everything throw aside cant. But more than this, I hold that every prescription ought to be as far as possible a proving, or rather that we ought so to prescribe remedies that something may be learned from each prescription. This may be considered as nothing

more than emphasizing what Hahnemann has already stated when he insisted upon the prescription of a single remedy ; and to a certain extent it is so, only that the exuberant valuation put upon the proving implied an impossibility of adding to or correcting it by subsequent clinical revelations. From the earliest time in homœopathy we started as though the proving of all substances had been completed, which was far from being the case ; in fact we professed more than it was wise to have done, and the consequence is, I take it, we impeded progress. Thus Dr. J. P. Dake expresses the opinion of a large portion of the homœopathic body when he says: "In my writings I have seldom ventured to display cases and prescriptions for the very reason that prevented Hahnemann's doing so, viz. : the faith one should have in the homœopathic law applied to a pure pathogenesis. A knowledge of drug effects on the healthy, and a faithful comparison of them with the symptoms of each case presented for treatment, has seemed to me of infinitely more importance in practice than a reliance upon the revelations of clinical experience, a source fruitful of all manner of empiricism and uncertainty."—*HAHNEMANNIAN MONTHLY*, June, 1892.

This seems to me very like saying that we have run aground and should stay there ; for certainly if clinical illustration of provings is not to be encouraged we shall have provings remaining as that of *calendula* has done, an incumbrance, useless and unused and in every way burdensome. For up to the time of my publishing papers that ran through the *Homœopathic World*, in 1890, '91, and '92, and which contained a series of some eighty cases of aural disease treated by *calendula*, its provings had done very little to cause the marigold to be employed in the internal treatment of disease, although its pathogenesis contained most excellent indications for its administration.

Nor will the plea that *calendula*'s proving is too meagre for practical use afford sufficient explanation of its inutility.

Sulphur, by some reputable students, is said to be over-proved ; yet its most important anti-periodic action was unsuspected until pointed out and illustrated clinically by myself in the *Monthly Homœopathic Review* and in the *British Journal of Homœopathy*. (*Vide*, "Sulphur as a Remedy for Neuralgia and Intermittent Fever," Henry Turner & Co., Fleet Street. 1869.)

But anyway the object of this investigation is not to throw over homœopathy, nor on the other hand to back up homœopathy ; it is to carry on an independent investigation which will start with a con-

fession of want of knowledge rather than an assumption of infallibility, and will in no way be a slave to systems. Thirdly and lastly, the idea had prevailed that medicines ought to be repeated. In stating that we must depend more upon the single dose we are again anticipated by Hahnemann, but only partially so. Hahnemann made but little distinction between acute and chronic diseases in respect of this question, and this is really the vital point. In acute disease, when inflammation is rapidly making inroads upon an organ, every available means must be resorted to to stay its progress; amongst these means without a doubt must be considered repeated doses of the indicated remedy, of the remedy, that is, which is known from its pathogenesis to be indicated. This I consider indisputable. But in chronic disease, in affections in which disease-force is making slow but sure progress, which have been from the outset gradually progressing, and especially where, as is so often the case, ordinary treatment has failed to arrest its progress, the circumstances are such as will render unobjectionable the prescription of a single dose, even when not known to be indicated; and it is to this single dose that we must have recourse for the arrest of all such ailments—of ailments, that is, which are slow and gradually progressive and rebellious to ordinary treatment. This is then one of the main principles upon which we start, that in such cases as gradually developing disease associated with, let us say, deafness as a symptom, the prescription of a single dose allowed to act for weeks together must be insisted on.

The present attempt, it cannot too often be repeated, is intended to lay down the lines upon which to prosecute research, “to give the route,” as it were, and not to found any new or startling system of medicine. Ask the majority of intelligent students of homœopathy what were Hahnemann’s three principal claims to the gratitude of posterity, and they will reply, in order; first, the annunciation and illustration of the law of similars; second, the insistence on the proving of drugs before administering them to the sick, and, third, the infinitesimal dose. For the purpose of our present inquiry I would place as first in importance the administration of a single and solitary dose independently, within reason, of its size, with full interval; second, the law of similars, and third, the scientific pathogenesis of the remedy. In a word, reliance must be placed upon the administration of the drug in a single solitary, and uninfluenced dose, as being a proceeding the best calculated for purposes of establishing a cure of a disease, as well as for investigation of the drug’s

action. Let it then be clearly understood that the principal object is to obtain, it may be, but one characteristic feature of the curative action of some few common plants; and, if it seems good, to comment upon the significance of this feature, whatever it may be, so as to arouse an interest in the possible medicinal virtues of the drug. Two very wide-spread ideas have sunk deep into the human mind, both lay and professional; the first is that desperate diseases are by desperate remedies cured; and the second that food and physic are under the same laws. Let us then, before we go further, discuss these pronouncements. Desperate diseases often, but by no means always, require desperate remedies, when these diseases are accompanied by tissue change that is beyond the reach of drugs; thus a constriction of the bowel may require serious operation for its removal; so of ovarian tumors, urethral strictures, and a host of other affections. But when by a desperate disease we mean an affection which by a process leading to gradual enfeeblement of an organ has so weakened its powers as to deprive it of its functions, the pronouncement that such requires a desperate remedy is as misleading and as untrue as anything can possibly be.

That food and physic are not under the same laws has been abundantly proved by Hahnemann and his followers, notable among whom was Grauvogl, and I refer to it now only to insist upon the evil tendency engendered—albeit involuntarily—in our minds of its being necessary to administer medicine like food three or four times a day. This is a legacy of old-school physic which probably has done more than anything to hinder the progress of scientific curative medicine. I cannot conceive anything more humiliating or more unsatisfactory than the constant prescription of drugs to patients who are obliged to go on taking them several times a day for weeks or months together, and this for no better reason, were we to analyze our feelings, than because they are accustomed to do so, and that their instincts in this respect are hereditary. The habit that as homœopaths we have formed of exhibiting remedies from a pocket-case, and getting the patient to take repeated doses, is vicious to the last extent, and entirely precludes the possibility of collecting clear evidence of drug power.

It is, for the purpose of this investigation, more important to know in what way to administer a drug than to know what is, within reason, the right drug to select. The single dose must, before everything, be insisted upon, my contention being that we are dealing with cases, when treating chronic ear diseases, that are not curable in any

large proportion by repeated doses of the well indicated remedy, but which are curable in a very large proportion by means of even an imperfectly indicated remedy if given in single dose and with sufficient interval. If any one wishes to quarrel with this statement, let us hear how matters at present stand, and if the position is such as Dr. Bæhr states, then in heaven's name give every encouragement to an honest attempt to alter it. "As regards diseases of the ears," says Bæhr, "we are still worse off than in the diseases of the eyes. In general, the diagnosis is a very difficult one, sometimes impossible. How then shall we be able to select the right remedy? We have to confine ourselves to furnishing a cursory and condensed list of the pathological conditions and remedies with which a somewhat empirical and not very reliable use at the sick bed has made us acquainted; for the selection of a remedy in accordance with symptomatic similarity is still more deceptive in the case of ear affections than in other morbid conditions; nevertheless it happens but too often that we have nothing else to fall back upon than symptomatic similarities."—*Sci. of Therapeutics*, by Bernhard Bæhr, vol. i., p. 257.

The term symptomatic similarity may lead us very grievously astray. Dr. Richard Hughes and many other modern homœopaths require very definite proof of special local action on the part of a drug before they admit the existence of symptomatic similarity; and though scientifically, in thus laying down the law, they appear right, in reality they but create an unnecessary difficulty. And when in pursuance of our contemplated inquiry I decline in every case to require proof of similarity, it is because the conviction arrived at from years of inquiry into drug action has become an established one,—that every drug when given in doses not immediately irritating in its own way, acts upon every part of the body, the ear not being an exception. Every plant that grows is in sympathetic relationship with the human body, and the first thing we have to learn is the way in which the plant-force—the growth-force or the dynamis, by whatever name we like to call it—can best be given so as to exert a beneficial action upon disease, the mode of administration being therefore all-important for investigation purposes. The mode of administration of the remedy, then, being so much more important than the mode of selection, is a truth limited by the circumstances, and only to be taken as applicable to our present investigation.

Given, say, a field of plants from which we are obliged to select remedial agents, and given the class of diseases to be those of the

ear, what I mean to affirm is this: that I am prepared to walk into such a field and to allow any one to select from it whatever forms of growing vegetation he may wish, say, for instance, some twenty plants, and that with the tinctures I will make from these I am ready at any time to treat ear disease more successfully with the single dose and sufficient interval than can be done by any *constantly repeated* remedies whatsoever, whether selected homœopathically or whether administered after the old-fashioned and ill-defined principles of allopathy. This I feel to be a fact, and I am prepared at any time to substantiate it, and facts are things that we must, if we are to make progress, look at straight in the face. In Hahnemann's words: "How unmeaning and ridiculous is *mere theoretical* skepticism in opposition to the unerring, infallible, experimental proof."—*Organon*.

It will be argued that if the force with which we are dealing be in reality a growth-force, the plants of most rapid growth will be those most available for medicinal purposes. This by no means follows. A growth-force that will at one time rapidly multiply the cells of the bovista or will bring into being the exquisite shelter afforded by the gourd, and at another will distribute the form and color of the orchid, is a force that is exercised in very many ways and under very diverse circumstances—that is all. Until facts warrant we cannot argue anything from such phenomena, but when facts suitable for our purposes are elicited, then, and not till then, should we declare ourselves.

More than this, should it at any time appear that errors have been made in our deductions, or that suppositions were put forward that will not comport with further research, I ought to be and trust I am every ready at once to review such, and readily to accept correction.

Upon one subject I wish particularly to review published statements. This is the subject of the dilutions. If the force with which we are dealing is in reality a growth-force, it will almost follow that power to act curatively does not depend upon the material property of the medicament we administer, and that consequently the dilutions, as well as the primary tinctures, are available for our purposes. This being the case, I am in no sense an opponent of the method adopted by Hahnemann of expansion of the remedial particles by means of succussion and trituration. But, as yet, so far as I have gone, I see no reason whatever for such preparations, the single dose answering all the requirements that can reasonably be expected from

medicines. To take the well-known example of cure given as a typical case by Hahnemann :

“Sch—, a washerwoman, somewhere about 40 years old, had been more than three weeks unable to pursue her avocation, when she consulted me, September 1, 1815.

“1. On any movement, especially at every step, and worse on making a false step, she has a shoot in the scrobiculus cordis that comes, as she avers, from the left side.

“2. When she lies she feels quite well ; then she has no pain anywhere, neither in the side nor in the scrobiculus.

“3. She cannot sleep after 3 o'clock in the morning.

“4. She relishes her food, but when she has ate a little she feels sick.

“5. Then the water collects in her mouth and runs out of it like the water-brash.

“6. She has frequently empty eructations after every meal.

“7. Her temper is passionate, disposed to anger. Whenever the pain is severe she is covered with perspiration. The catamenia were quite regular a fortnight since.

“In other respects her health is good.”

Hahnemann then inquires into the indicated remedy and sums up thus: “Now, as this woman was very robust, and the force of the disease must have been very considerable to prevent her by its pain from doing any work, and as her vital forces, as has been observed, were not consensually affected, I gave her one of the strongest homœopathic doses, a full drop of the pure juice of bryonia root, to be taken immediately, and bade her come again in forty-eight hours.” The report then goes on to say that the patient neglected to return, but was ascertained to be quite well by his friend E., who had been present when the prescription was given ; and Hahnemann appends this remarkable note: “According to the most recent development of our new system the ingestion of a single, minutest globule, moistened with the decillioneth (x) potential development, would have been quite adequate to effect an equally rapid and complete recovery ; indeed, equally certain would have been the mere olfaction of a globule the size of a mustard-seed moistened with the same dynamization, so that the drop of pure juice given by me in the above case to a robust person should not be imitated.” And why on earth, I feel inclined to ask, should it not be imitated ? it is absurd to suppose that a drop of the pure juice could have effected harm by reason of its material quantity. Here, then, we have an arborivital remedy acting with

untold force upon disease; and while I quite agree with Hahnemann that a dilution of the remedy would, probably, have acted quite as well, I yet want to know what the objection is to the use of such a dose as one drop of the pure juice of a plant given by itself.

Hahnemann here shows his anxiety to advocate the claims of his own special preparations; and well he might do so, seeing what opposition these occasioned, and that it was through these specially that he was placed upon the defensive; but the important fact for us to remember is that he was then keenly alive to the enormous force with which the single dose of a remedy acts, and that it was with this dose, *given as we are now giving it*, that is, undynamized, that he gained his early successes, and with which many of his so-called provings on the healthy were evidently made.

Let us then develop this phase of Hahnemann's system, and see to what conclusion it will lead us.

(*To be Continued.*)

THE IMPORTANCE OF SUSPECTING A POSSIBLE RELATION OF CAUSE AND EFFECT BETWEEN CHRONIC DIFFUSE NEPHRITIS AND UNYIELDING AFFECTIONS OF OBSCURE PATHOLOGY.

BY WM. A. HAMAN, M.D., READING, PA.

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THE establishment of a diagnosis after the failure or success of a special line of treatment is not always an evidence of lack of diagnostic acumen. In the study of semeiology it must have become apparent to every one that diseases of the same organs, quite distinct in their nature and pathological anatomy, may manifest their existence by the same train of symptoms; and gross changes in one set of organs can, either directly or indirectly, occasion lesions in other localities, so similar in appearance and effect to other more common affections of the same locality, that the true differentiation can only be accomplished after extensive treatment.

The prompt disappearance of lesions and symptoms, dependent upon the virus of syphilis and malaria, following the use of certain drugs, is the most common illustration of post-therapeutic diagnosis to which allusion can be made. But these are not the only diseases

the diagnosis of which, at times, cannot be established until after treatment. In some cases of chronic diseases of the kidneys it is possible to determine the dependence of other lesions upon the systemic changes due to the renal disease by well-directed treatment. So far as my observation goes, there are perplexing complications that arise in the course of renal diseases that are not alluded to in our medical text-books; these are all the more embarrassing when the renal disease is marked.

These complications certainly merit study, as relief can thus be afforded that would be impossible if unrecognized. Therefore, the importance of bearing nephritis in mind, as well as the other grave constitutional changes, in obscure affections in which one would not expect to find any relation as cause and effect.

An exceedingly interesting and instructive case illustrating the connection between nephritis and unyielding secondary affections, was under my care two years ago.

On December 19, 1890, I was requested to attend Mr. D., who was afflicted with obstinate ulceration of the lips, both upper and lower. I obtained the following anamnesis: He was 48 years old, and always enjoyed the best of health, his only illness being an attack of malarial poisoning during the civil war. Toward the end of October, 1890, he had a few teeth extracted, and in a few days noticed some stiffness and fulness about the lips. He paid no attention to this, and continued at his usual occupation, that of conductor on a passenger train, during the whole month of November. In the middle of the month he consulted a physician of another city, who prescribed a mouth-wash. On December 1st, his pain and swollen features compelled him to place himself under the care of his family physician, who attended him daily.

Sloughs now showed themselves on the mucous surfaces of the lips for the first time after about five weeks of swelling. Owing to a trifling disagreement with his physician he placed himself under my care on the 19th of December. I found the following condition: He presented a healthy appearance and was well nourished. His lower lip was swollen, and on its free edge in the right angle of the mouth were to be seen the upper surface of sloughs that dipped deeply into the substance of the lip. The upper lip was swollen to a less extent and had a superficial slough at the place opposite the left upper canine tooth. The skin covering the swollen portions of the lips was red and tense. The gums were not ulcerated, neither was there any pharyngeal trouble. He had an apron tied around

his neck to catch the somewhat increased flow of saliva that could not be retained within his mouth. He felt well, roamed about the house, had a hearty appetite, but found considerable trouble in satisfying it, and in consequence often left the table hungry rather than submit to the aggravation of the pain caused by eating.

To me, at the first glance, it seemed a trifling affection, and I thought I could easily detach the sloughs and rapidly bring on the desired cicatrization. But the fact of the existence of the inflammatory swelling for five weeks, before the appearance of the sloughs was very peculiar, and I supposed it to be due to some constitutional condition. Diabetes mellitus, syphilis, and mercury, suggested themselves as possible underlying causes, but there was no increase in the quantity of urine, and after close examination I could not find any direct evidence to support the syphilitic theory, and the normal gums and teeth sockets, with the denial of the use of any medicine, effectually disposed of the theory of mercurialism. However, I administered our antisyphilitic remedies, mercurius, nitric acid, kali iod. and merc. jod. rubr. without any effect. Locally the use of antiseptics, carbolyzed washes, iodoform, permanganate of potassium for the fetor, and calendula, nitrate of silver, both in solution and stick form as stimulants were most tantalizingly ineffective. I was forced to commit myself to a diagnosis, as the gentleman belonged to two beneficial organizations which required a weekly certificate containing the diagnosis. For want of a more accurate one I termed the disease stomatitis gangrenosa, knowing that it was anything but a classical case. When I first met my patient he was about the house, feeling well. In a short time, however, he lost his appetite and became dejected and took his room and began to rapidly lose flesh. The ingestion of food became very difficult; to this and the swallowing of septic mouth fluids I attributed the rapid decline. The character of the pain experienced so far was a sudden lightning-like darting pain, accompanied by twitching of the facial muscles at the time of pain. These darting pains became so severe and frequent that his rest at night was so broken that he dreaded its approach (magnesia phos., 6x trit. seemed for a time to make the dartings more bearable). The lip lesions were gradually spreading. The whole lower lip became very much increased in size, and after remaining so for ten or twelve days, the induration not softening as though suppuration was occurring, the mucous membrane became detached, revealing an extensive slough involving the whole thickness of the lower lip at the right angle of the mouth.

While this process was going on a similar induration existed in the substance of the left half of the upper lip; this did not form one extensive slough, but numerous small ones, the exposure of which through the skin of the upper lip made it look like the top of a carbuncle, there being nine openings. The nose was also affected. The alæ nasi and tip of the nose became swollen, red, and very painful, as is the case with inflamed cartilages due to a tense perichondrium. At this time, seeing its slowly destructive tendency, I was considering the advisability of destroying all the partially devitalized tissue with nitric acid as in the treatment of stomatitis gangrenosa, when I was struck with the contrast between the forcible radial pulse and the man's marked general weakness. The scales fell from my eyes, figuratively speaking, and a hurried examination revealed a hypertrophied left ventricle with the impact of the apex beat well to the left of the nipple line. The examination of the urine that followed revealed the presence of albumin in small quantity, no sugar, and hyaline, granular and epithelial casts in every slide. This was about the middle of January. I had several times questioned him regarding the appearance and amount of urine and was assured that it was normal in appearance and the quantity was neither increased or diminished, and had been culpably satisfied with this answer. The second sample of urine was mixed urine, the quantity in twenty-four hours amounting to but twelve and a half fluidounces. The specific gravity was 1020, it was acid in reaction and cast a copious lateritious deposit, consisting of uric acid crystals and fibrinous tube casts; albumin was present in small amount; the percentage of urea was 2.6 per cent., a normal percentage but the decreased amount of urine contained but 153 grammes, representing the twenty-four hours output, the normal range being from 450 to 600 grammes. Extended observation showed the range in quantity to be from 12 to 16 fluidounces, and the amount of urea to range from 150 to 175 grammes. Three times, in more than a dozen examinations, the quantity rose to 20, 21 and 21½ fluidounces, and this was accompanied by a fall in specific gravity from 1020, the usual specific gravity, to 1016 and 1015; the amount of urea excreted these three days was 200, 205 and 215 grammes respectively. Questioning revealed the following additional facts: He never did heavy manual labor and was always a large eater, particularly of nitrogenous foods; this is very significant. For the past six months he was a great sufferer from frequent, in fact daily, frontal headaches. In the daytime he was dull and drowsy. For years he had been obliged to get up

regularly every night to urinate, and for the past two years has had frequent epistaxis; this would generally come on at night in bed, accompanied by a terrible throbbing frontal headache, and would average one attack a week and be very profuse. At no time throughout the course of his tedious illness could I detect a trace of œdema either about the eyelids or ankles. These facts with the hypertrophy of the left ventricle and tense radial arteries made the presence of chronic diffuse nephritis, with predominating interstitial sclerosis, a certainty.

In the absence of any other discoverable associated disease, I was forced to the conclusion that the destructive ulceration was the consequence of the systemic results of the renal changes. The renal incapacity, as shown by the marked decrease in the principal solid elements of the urine, naturally resulted in the retention in the blood and tissues of the waste resulting from catabolism or physiological disintegration of tissue. This naturally impaired the physiological ability of the tissues, and in consequence of a trauma to the lips at the time of the extraction of the teeth, they could not resist and limit microbic invasion; hence the devitalization of tissue. If this view was correct, then by increasing the amount of urine and ridding the blood and tissues of effete material, the physiological resistance of the tissues would be increased, the spread of microbic invasion would be limited, and cicatrization would be favored. In casting about for a suitable diuretic, after one unsuccessful trial, I determined upon the use of fluid extract of apocynum cannabinum. I commenced by giving 5 gtt. every four hours. At this time a severe hæmorrhage from the ulceration in the lower lip came on so profuse and protracted as to make me fear death from this cause; ergot in massive doses finally controlled it. Soon after commencing the use of apocynum the urine gradually increased in quantity until 30 fluidounces per diem were reached, and then a perceptible change occurred; the severe darting pains and muscular twitching became less frequent, and bodily and mental lethargy were replaced by activity and renewed interest in general affairs. The doses of the fluid extract of apocynum were increased gradually to the point of intolerance; if more than 20 gtt. every four hours were given, he felt badly. This dose was maintained for weeks, as by it the maximum output of urine was reached and kept up, 40 to 48 fluidounces per diem. It is noteworthy that, while taking these large doses of apocynum, the frequency of the heartbeat was unaffected, the pulse ranging from 80 to 90 throughout the whole illness; at no time was retardation noticed.

After the quantity of urine reached 40 and more fluidounces in the twenty-four hours the acute inflammatory symptoms slowly subsided, the induration softening and a more healthy appearance obtaining. The specific gravity of the urine falling as the urine increased in quantity showed plainly the inability of the renal epithelium to excrete a correspondingly increased amount of solid urinary elements, and although the quantity of urine almost reached that of health, yet the daily output of urea ranged in the neighborhood of 300 grains, thus not quite doubling the amount of urea. As the excretion of urinary solids did not reach that of health the healing process was correspondingly slow, but was uninterrupted, and progressed until complete cicatrization was effected. This was in April, 1891, six months from the commencement of the lip trouble. But the ravages of the destructive ulceration are only too apparent. The lower lip at the right angle of the mouth is practically gone, and the gap makes it impossible to retain the saliva, and the left half of the upper lip is so thin that the cicatrix rests upon the left superior maxilla. The cartilage of the septum of the nose is entirely gone, the septum consisting only of the bony portions, the vomer and perpendicular plate of the ethmoid, except a cylindrical strip of skin, the thickness of a darning-needle, extending from the extreme tip of the nose to the anterior nasal processes of the superior maxillæ.

In fact, the facial disfigurement is so marked that he could not regain his position as passenger conductor, but was obliged to be content with the position of baggage-master. On glancing into his nostrils without illumination nothing of the septum is seen but the narrow strip of skin just referred to. I was both gratified and humiliated with this result. Gratified, as I had given a very unfavorable prognosis when I became convinced of the dependence of the ulceration on the renal disease and humiliated at the thought of what might have been prevented by "grasping the situation" earlier. I put my conviction of the relation of effect and cause existing between the ulceration and chronic diffuse nephritis to a severe test, giving nothing but the diuretic, and insisting upon the use of distilled water as a drink instead of city water, hoping by this means to increase the solvent power of the urine. Locally, I continued the use of what had been unavailing agents to insure cleanliness. For a short time I used plumbum met. because of its homœopathicity to this form of renal degeneration, but discontinued it long before healing was affected.

Naturally I ransacked the medical literature at my command for parallel cases, but my labors were fruitless. Although I know that this case is not unique, yet I am convinced that it is anything but common. To my delight I found reference to this very condition a few months later when the 1891 edition of the *Annual of the Universal Medical Sciences* appeared. In volume 1, section L, page 21, the following occurs: "Barie calls attention to a uræmic phenomenon in the form of a stomatitis, for which he proposes the name 'uræmic stomatitis.' Its manifestations are to be seen upon the tongue, lips, gums, inner surface of the cheeks, isthmus and pharynx. It presents itself in softened patches over the mucous membranes, or as softened and erythematous areas or as ulcers. *These changes are probably due to efforts on the part of the mucous membrane to eliminate certain substances.* The softened, pultaceous forms are apt to precede the ulcerous, which is the only one of any severity in itself, being accompanied by excessive salivation, fetid breath and great difficulty in mastication, and being usually met with in conditions of grave general adynamia. Any pathological state of the oral mucous membrane, chronic irritation from tobacco, bad state of dentition, gingivitis, etc., all dispose to the easy appearance of the symptom. For the treatment Barie recommends, as local measures, touching the ulcers with salicylated glycerine, or a solution of chloride of lime, or lemon juice and the stick of nitrate of silver, combined of course, with general measures for the uræmic state."

I cannot agree with the sentence that I have italicized; this explanation, to me, appears to be inadequate.

The subsequent history of this individual is interesting. Shortly after his return to the road his fellow-workmen brought complaint against him, claiming that the drooling of saliva made them liable to contract syphilis, asserting that the cause of his disease was of that nature, basing this on rumors afloat during his illness, and which I had been obliged to contradict to the representative officers of the relief association of the railroad. In consequence he was discharged, no reasons being given. He insisted upon having them, whereupon he demanded a rigorous examination by the examining surgeon of his division. This was granted, and after the most searching examination, failing to show any palpable syphilitic lesions, he was restored to his position on the road. He is still living, but as I have not seen him for almost a year I do not know what his present condition is, but I do know that he has had no further trouble with the ulcerated lips. The presentation of this paper to a homœopathic

medical society may seem unsuitable, as the use of the successful therapeutic measure was not based on the law of similars. I acknowledge the force of this criticism and my excuse for selecting this subject is to help to enlarge our knowledge of obscure conditions and thus make our knowledge of clinical medicine more valuable to suffering humanity. So far as the treatment of the case I described is concerned I believe that had he been treated strictly homœopathically he would have died a miserable death. There is a point reached in the history of chronic diffuse nephritis when nothing short of a marked increase in the discharge of effete material can save life. In the disease in question, diffuse nephritis with interstitial sclerosis and general arterio-capillary fibrosis, I believe that in the early stages, with proper hygienic precautions and suitable homœopathic remedies, the progress of the disease can be retarded, and in some cases even held in check until the individual outlives his expectation of life. But when the greater portion of the glomeruli and uriniferous tubules are strangulated and the point referred to is reached, homœopathic remedies, the action of which is addressed not to the healthy but to the diseased portions of the renal tissue in the hope of checking the march of fibrosis, cannot exert any influence tending to the saving of life, and treatment must be instituted directed to rousing the latent energies inherent in still uninvolved renal tissue. If this is neglected an outbreak of uræmia is inevitable. Any agent stimulating but not irritating to the renal parenchyma and able to so stimulate the feeling powers of the hypertrophied heart as to enable it to increase the tension in the renal arteries by overcoming the resistance offered by the sclerosed arterial system will produce beneficial diuresis. If this is unattainable then purging and diaphoresis are to be mainly relied upon. Unfortunately when this latter stage is reached the scene soon closes.

LA GRIPPE.

BY EDUARDO FORNIAS, M.D., PHILADELPHIA.

A. Definition.—An epidemic, infectious disease, of variable intensity and aspect, characterized by fever, cerebro-spinal depression and exaggerated epithelial desquamation, with symptoms more or less marked of ocular, nasal, pharyngeal, bronchial and sometimes gastro-enteric catarrh.

B. *Ætiology*.—Essentially epidemic, spreading with great rapidity, covering wide areas in a very short time and following no determinate direction in its course. *Contagion*, doubted by some, admitted by others, probably slight. The influence of ozone has not been proved. Most likely of bacterial origin. It is apparently independent of climate and season, and it is not inoculable (Bristowe). It is the most typical of epidemic diseases. It strikes with preference the adult. It affects sometimes women and children in a special manner. It is prone to influence the character of pre-existing affections, the rheumatical become more rheumatic, the neurasthenical more neurasthenic, etc. Sometimes the disease breaks out even at sea. It appears to have some relation to diseases of the lower animals (Collie). A first attack confers no immunity, but rather predisposes the system to relapses.

C. *Symptoms*—1. *Common Form*.—*Onset*, sudden, with a sense of *chilliness* down the back, or decided *chills*, alternating with *flushing* and *heat of the skin*. *Fever* of variable intensity (101° to 104°), sometimes very slight, intermittent or remittent in type. *Pulse* accelerated, rarely strong, sometimes small and feeble, irregular, modified in a few hours in the same patient (Graves). *Great prostration*, out of proportion to the intensity of the fever and catarrhal inflammation, persisting for days after the subsidence of the fever, and even during convalescence; *violent headache*, frontal, supra-orbital, occipital, epicranial or involving the eyeballs; *severe muscular, peri-articular*, sometimes *wandering pains*, *depression of spirits*, *vertigo*, *tendency to syncope*, *perverted cardiac action*, *peripheral neuritis*, *cutaneous hyperæsthesia*, *restlessness*, *sleeplessness*. *Ocular*, *nasal* and *pharyngeal catarrh*, with their accompanying symptoms; *soreness* and *watering of the eyes*, *dryness* and *itching of the nose*, *sneezing*, *acid nasal flow*, *epistaxis*, *loss of smell and taste*, *sore throat* and *painful deglutition*. The catarrh may extend to the *larynx* when corresponding symptoms are noted; *hoarseness*, *dyspnœa* and a *harassing, paroxysmal*, sometimes *painful cough*, first *dry*, later with *bronchial expectoration*. Occasionally the eyes, nose and pharynx remain free of all catarrhal trouble, and the disease starts with a *laryngo-bronchial catarrh*, and in addition to the above symptoms we may have a *sense of rawness in the fauces*, *larynx* and *trachea*, more or less *soreness beneath the sternum*, a *feeling of tightness or constriction about the throat and chest*, *sonorous and sibilant râles*, limited to the large bronchi, and as in all febrile catarrhal affections, *evening exacerbations* and *morning remissions*. *Anorexia*, *thirst*, *coated tongue*, *foul*

breath, constipation. Gastro-enteric catarrh, epigastric pain and tenderness, red tongue, nausea, vomiting of food or bile, diarrhœa, cramps, sometimes dysentery, and icteroid color of the skin and conjunctiva. Febrile, offensive urine; sweating, partial or profuse; and occasionally eruptions resembling urticaria, measles or scarlatina. (Many of the rashes observed during the last and present epidemics have been ascribed, by high authorities, to the injudicious use of antipyrin.)

2. *Severe Form.*—*Exaggeration* of the above symptoms with serious localizations, either on *the respiratory tract* (bronchitis, broncho-pneumonia, pleuro-pneumonia, congestion of the lungs, etc.); on *the nervous system* (intermittent, soft pulse, cardiac weakness, palpitations on the least exertion, actual syncope, collapse, delirium, stupor, coma, convulsions and sometimes mental perversion, amounting to true mania, melancholia and even insanity), or on *the gastro-intestinal canal*, presenting a cholera-like syndrome.

Now, let us imagine all the possible states of transition, attenuation and intermixture between the two preceding morbid groups, and we shall have an idea of the numerous clinical varieties that may come under our observation. But, of course, even then, as the following group will show, we would not have all the epiphenomena and syndromes that have been observed during the evolution of this whimsical affection.

3. *Anomalous Forms.*—The predominance of certain symptoms, or groups of symptoms, as well as certain localizations, have given to each epidemic an individual character. The following have been observed: *Broncho-pulmonary* (1837, 1886, 1890). Great many died from *capillary bronchitis* and *broncho-pneumonia* (Noriat, Menetrier). It should be stated just here that besides the broncho-pulmonary complications inherent to “la grippe,” there is to be noticed occasionally a *true, lobar pneumonia, infectious and infecting*, with all its pulmonary and extra-pulmonary manifestations, pleurisy, endocarditis, pericarditis, meningitis. Moreover, the study of previous epidemics has plainly shown that while pneumonia has come to complicate la grippe, it does not only take place as a complication, but that it occurs also primarily, constituting a concomitant epidemic; and again in the *grippal pneumonias* observed in 1886, Menetrier fully demonstrated the presence of the *pneumococcus*, not only in the sputa, but in the pulmonary hepatization after death and in the blood during life. Consequently, says Menetrier, we may

conclude that grippe and pneumonia are two independent affections, but with a marked affinity the one for the other. La grippe seems to predispose to pneumonia, and both appear to be favored by the same causes.

Suffocative (1830, Irland).—In this epidemic the respiratory tract was nearly free of catarrh, and nevertheless an intense early *dyspnoea* unexpectedly appeared. According to Graves, it was due to a direct disturbance in the function of the vagus. In other epidemics the *orthopnoea* and *suffocative attacks* were also common.

Anguinose.—The inflammation of the pharynx and tonsils has been sometimes so predominant that foreign observers have described a type under the preceding heading. In this variety the *redness and painfulness of the pharynx* were marked, and many patients complained of *soreness in the post-nasal region*. *The tonsils were red and swollen*, and in many cases *suppuration occurred*. *The difficulty of swallowing* was very distressing. *Purplish spots were noticed on the pharynx and soft palate* (Dieulafoi), and also *aphthous ulcers in the fauces* (Backer). In children, *pharyngitis* and *amygdalitis*, simple or pseudo-croupal, as well as *ulcerative glossitis with congestion of the gums*, were observed in 1890, by Dr. Villard, of Marseilles. During the present epidemic, I had three cases of severe tonsillitis with suppuration, but they occurred in patients who had had repeated attacks of this trouble.

Aural.—During the last and present epidemics, *inflammation of the auditory passages* has been universally noticed. In some cases, only *otalgic pains* were present, but in others the *aural catarrh* was attended by *great pain and sensitiveness in the mastoid process and in the region of the Eustachian tube, as well as deafness and tinnitus*. Cases of *true otitis* ended occasionally in *suppuration and perforation* of the *membrana tympani*, which, as a rule, healed readily, but a few *meningeal and cerebral complications*, by extension, have been recorded. Michel, of France, has described two varieties of *grippal otitis*, one localized in the external meatus, the other, consecutive to a *concomitant catarrhal salpingitis*, situated in the middle ear. According to Netter, a certain number of these auricular lesions are caused by the *pneumococcus* and *streptococcus*. At the December meeting (1891) of the Medical Society of Berlin, Dr. Fränkel reported six cases of otitis, four of which ended in perforation. In the *Arch. Ohrenheilkunde*, Jansen reports 100 cases of otitis after influenza, which he observed at the University clinic in Berlin. In one-seventh of these cases, no perforation occurred, and the attack soon

passed away. A few times he found the hæmorrhagic vesicles on the inflamed tympanic membrane; twice the mastoid process became affected. In the largest percentage of cases perforation occurred. Cases of *continued deafness* have also been recorded.

Ocular.—Besides the *conjunctival hyperæmia* attending the early *coryza*, *ophthalmias* more or less intense have been observed, during the climax and convalescence. Dr. Landolt describes, in *La Semaine Médicale*, three principal forms of *ocular lesions*: 1st, *acute oculo-palpebral conjunctivitis*, involving the superficial layers of the sclerotic, and attended by swelling of the lid-follicles; 2d, *palpebral œdema*, with or without conjunctivitis; this œdema is white, soft, of an indolent nature, and appears suddenly at night, the patient awaking in the morning with puffed-up eyes; 3d, *abscesses of the lids*, sometimes occurring several weeks after recovery, superinducing fever, containing a very fetid pus, and demanding early incision. In this country, during the prevailing epidemic, *conjunctivitis, with or without coryza, has been very rare in the adult, but almost constant in children.* In these cases, *photophobia* has been a distressing symptom.

Laryngeal.—If the prevalence of certain symptoms, or severe localizations, do allow of a classic description into various forms, then we are justified in including here a laryngeal type, for no part of the air-passages has been so notably impressed by the disease, during the present epidemic, as the larynx. I have treated cases in which, with the *laryngeal irritation*, and *persisting, paroxysmal cough*, there appeared soon after the most excruciating headache and backache. At other times, the trouble commenced with *great laryngeal soreness, harassing, painful cough, and huskiness*, the latter sometimes amounting to true *aphonia*. Some patients complained of *rawness beneath the sternum and a feeling of tightness about the throat*. In the majority of cases *the cough, which was almost always dry and worse at night, persisted unabated* for days and weeks after the other symptoms had passed off, but many who were prudent and remained in-doors, recovered quickly. Another persisting symptom was *hoarseness*, increasing with the least excitement, and after continued use of the voice. In a few cases, *tonsillitis* attended the laryngeal trouble. I have observed also very mild cases, with only a moderate amount of irritation and constant hoarseness.

Cardiac.—In certain localities, careful observations have plainly shown a direct action of the infection upon the heart through the nervous system (bulb and pneumogastric), and this was especially

the case in 1890, in France, and in 1867, in Russia. During the last and present epidemic, I have noticed, at the outset of the disease, frequent palpitations, which were exasperated by the least emotion or fatigue. A soft, easily compressible pulse, even when rapid (120 and more) was considered a bad sign, and this was undoubtedly due to *weakness of the cardiac impulse*.

Occasionally the *cardiac weakness* was such as to produce *collapse* and *death*, a termination frequently observed by Dr. Botkine, of St. Petersburg, during the epidemic of 1867. Under these circumstances severe and even fatal *syncopes* occurred, either from *myocarditis* (verified in several autopsies by Dr. Vasiliev, at the Alexander Hospital of St. Petersburg), more probably from a *paretic condition of the vagus*, or by *interference with the function of the bulb* (Villard). But *syncope* is not always of such a severe character; the *syncopal form*, as it has been called, may be very mild; a *grippe* of medium intensity frequently commences with *pallor of the face, which is soon followed by fainting*. This syndrome, however, is not persistent, and soon disappears. Besides the severe and mild forms of *syncope* described, we may still meet with true *syncopes* of short duration, several attacks occurring in a day, without the life of the patient being in peril. Nevertheless, *syncope* is always a sign of functional disturbance of the nervous system, and should be watched with solicitude. Dr. A. Villard, of Marseilles, in his *Leçons Clinique sur La Grippe*, asserts: "C'est la grande loi d'élection de la grippe sur le systime bulbo-médullaire qui donne, dans le fait actuel, la clef des accidents. Le pouls se déprime bien vite; l'impulsion cardiaque fléchit comme à vue d'œil, et lorsque surviendra la syncope mortelle, vous accuserez encore le pneumo-gastrique."

So far it is through the nervous system that the heart has been directly attacked, but this organ may also be *secondarily affected* by the influence the disease exerts upon the *circulatory tract*, for the highly congested lungs, overloaded with carbonic acid, come then to increase the cardiac tension and contribute to render the function of the heart more difficult. Now let us suppose a patient whose heart is already hypertrophied, its valves are insufficient, its orifices contracted, and even its tissue altered. With functional troubles more or less pronounced, he lives in peace with his enemy, a relative peace, of course, but without safety for the future. He contracts the grip, which in its thoracic form will surely give rise to redoubtable accidents; the equilibrium is lost, compensation ceases to exist and *asystolia* with its known trails appears, bringing about profound

trouble in all the organic functions. If the cardiac lesions are not very pronounced the storm may pass off, but the crisis produced will certainly render the situation more grave. On the contrary, if at the time of contracting the disease the lesions are already in an advanced stage, a rapid death may be the result.

Delirant.—The observations of Mairét, of Paris, at the *Asile* (1890), as well as ours in this country, show that during the course of the disease, and even during convalescence, no few patients were suddenly seized either by a *hypermaniac delirium*, with marked sensorial perversions, or by a *vesanic* or *maddening delirium* (*folie grippale*) with impulses to suicide and homicide, and that these impulses were principally paroxysmal. All sorts of hallucinations and manias have been observed. Already in 1790, Benjamin Rush, of Philadelphia, referring to the then prevailing epidemic, says: "It had about the same characters as that of the previous autumn, but in certain cases it presented new manifestations. Some of the afflicted exhibited symptoms of *mental alienation*, and one of them jumped out of the window. Others were annoyed by blue colors and shadows passing before their eyes." Bonnet, of Bordeaux, speaking of the epidemic of 1837, mentions a case in which a *furious mania* developed at the outset of convalescence. Petrequier, of Paris, who made a synthetical study of the documents published about the epidemic of 1837, states that several patients were tormented by sad ideas, and that it appears that four or five suicides occurred, or were attempted, at the Paris Hospitals. And Grasset, of Montpellier, has recorded four interesting cases that occurred in his practice during the epidemic of 1890. The first was a little girl, ten years old, who during a whole day spoke of her approaching burial; she dealt with delight on this subject, giving orders and selecting with care those who were to attend to her funeral. The second, a young man, prepared himself to leave his room in shirt-sleeves to obey the dominant idea of his delirium, and only with much trouble he was put and kept in bed. The third, a young lady, was suddenly seized with an attack of *delirant hysteria*, which lasted one hour and a half; she complained of intense cold in the head and burning sensation in other parts of the body; she muttered continually, tossed about and tore her clothes, her legs became rigid and arched, and finally fainted. The fourth patient, on the arrival of a strange doctor, who had been called to attend her, began to give screams of terror, under the delusion that he was the devil. I am able myself to report two cases, one

which occurred in 1890, the other during the present year (1892). The first, a German, pocket-book maker, forty-one years of age, who, on being allowed to leave his bed, in the moment he put his feet on the floor was suddenly seized with vertigo and complained of being annoyed by red lights passing before the eyes; on the night of the day in which this happened he became delirious, and imagined that he was pursued by a man who was watching him from behind the door, and entreated his wife to send for a police officer. The *idea* of *persecution* lasted for about six days, and the patient gradually recovered. The other was a young lady, eighteen years old, who did not show any sign of mental aberration until convalescence, when she began to move about the room. This case was a complex one, for her raving was not directed to a single object; her delusory conceptions or hallucinations were varied, and always impelled her to acts of fury or vehemence; at times she maltreated her mother, abused those about her, broke glasses and other things within her reach, and used obscene language; again she prayed, cried or murmured, covered herself with flowers and trinkets, walked aimlessly about the house or wrote incessantly for hours absurd and incoherent sentences; frequently her ideas were of *grandeur*, considering the members of her family inferior to her in knowledge and position; while in bed her demeanor was lascivious or erotic, and complained of much itching at the vulva, which she scratched in an unchaste manner; several times she ran away, and on one occasion visited my office and behaved so bad that I had to use force to send her home. A persistent insomnia, untimely catamenia and obstinate constipation distressed her greatly. In this condition I consulted with Dr. Van Lennep, and it was thought convenient to give her special treatment, and through the influence of friends she was sent to Kirkbride, where she still remains improving slowly. As far as my observations go (this case excepted), the evolution of the delirium was always short, with the peculiarity that never was there a greater intensity of the disease while the delirium lasted, and that this seemed to be in relation with the temperament of the patient. The greater number of cases of mental alienation occurred during convalescence.

Somnolent.—In this form hebetude, torpor and sleepiness were very marked. The epidemic of 1712 was called the *sleepy sickness*, by reason of the prevalence of these symptoms.

Sudoral.—This form was noticed in London in 1782. In this epidemic the sweating was so profuse as to cause the name of *sweating sickness* to be given to the disease.

Uterine.—Observed in Paris in 1889 to 1890, and described by Dr. Felix de Backer in a pamphlet entitled *De l'influenza son evolution dans l'organisme feminin*. Its characteristics were *congestion of the ovaries, lumbo-sacral pains, uterine colic, pruritis vulva* and a *predisposition to abortion and puerperal fever*. In such cases the least pressure on the ovarian regions, especially the left, was very painful. The onset was frequently followed by a sudden arrest of the menses, while during the climax, especially after severe back-ache and tympanites, an untimely catamenia was induced, sometimes curing a pre-existing amenorrhœa. In the first case ovulation was undoubtedly interfered with, while in the second it was incited or precipitated. Another remarkable result, showing the infectious nature of the disease, was the offensive odor of the menstrual flow; in fact, all the discharges and exhalations observed during the grip partook of this foul odor, which was obviously due to an exaggeration of the epithelial shedding. Several cases of abortion followed by serious hæmorrhages also occurred.

Renal.—The last two epidemics (1889 and 1891) have shown a tendency to renal complication, and although such cases have not been numerous enough to form a characteristic group, the fact that albumin and casts (both hyaline and epithelial) have been frequently found, makes it worthy of our notice. These manifestations were attended by *violent and persistent pain in the renal region and head; quick, full and bounding pulse; high fever (103° to 104°) and scanty secretion of urine*. In the aged, retention of urine has not been a rare occurrence.

Infantile.—In children under seven years of age we have noticed principally *vomiting, sneezing and coughing, followed by fever with agitation, watery eyes, drowsiness, supra-orbital headache and frequently pain in the ears*. During the cough auscultation did not reveal anything but moist and sibilant râles. *Pneumonia* was the exception, and when the disease became localized in the lungs a *simple congestion without tendency to hepatization* was the rule. The site of the respiratory symptoms was the nose, the pharynx and the larynx, rarely extending to the bifurcation of the trachea. In fact the majority of children had only coryza, redness of the throat and a hoarse, sometimes whoopy cough, soon followed by tracheal secretion, but occasionally a *tracheo-bronchitis* was observed. The younger the child the more evident became these manifestations. As in the adult we often noticed many of the *nervous phenomena*, such as headache, pain in the back, loins and chest, as well as in the ex-

tremities and knees, and sometimes torticollis, but the *gastro-intestinal symptoms* predominated more frequently, and according to Dr. Comby, of Paris, *vomiting* was a leading feature of the trouble, during the epidemic of 1890. I have observed this abdominal form under various circumstances, but in a transitory manner. A nearly constant trouble has been the *oculo-nasal catarrh*, with *sneezing*, *photophobia* and *occasionally epistaxis*. Other symptoms reported in the French and German journals are *initial delirium*, *convulsions*, *pharyngitis* and *amygdalitis*, *simple or pseudo-croupal*, *ulcerative glossitis with congestion of the gums*; *cutaneous eruptions*, especially *scarlatinoid* and *morbilliform*; *epididymitis*, *abscesses* and *cervical adenitis*, *with and without suppuration*. Contrary to what usually happens in febrile affections of children *the temperature was seldom very high*, the rectal rarely reaching 104° , but it lasted longer than in a more advanced age, and with the same irregularities as in the adult. Towards the end of the disease the head of the little ones was often bathed with the sweat of the sudoral crisis. Sometimes the *hyperthermia* led other more serious symptoms, such as *delirium*, *prostration* and *excitability of the nervous system*, but in a more continued manner. The *depression of the forces* was still with them, one of the principal characteristics of the disease, especially during convalescence, which, as in the adult, was protracted and distressing. *The bronchial phenomena*, together with a languid condition of the system acquired frequently a rebellious persistency. Nevertheless observations everywhere have plainly demonstrated that the grave forms of the grip are unusual in children, excepting secondary pneumonia, which, although rare, occurs occasionally, assuming always the lobular form. As far as I know nobody has noticed in this class of patients cardiac complications or pulmonary troubles, imputable to the direct action of the grippal poison upon the nervous centres.

The preceding forms clearly show that while the different epidemics have had many symptoms in common they now and then have exhibited special phenomena by which they can be distinguished.

D. *Complications and Sequelæ*.—Of all the *complications* observed during the two last visitations of the grip, none was so frequent and serious as *pneumonia*; a pneumonia which often had an insidious onset, with very little pain in the side; where the crepitant râles were larger and more moist than in the true lobar variety, and where the tendency to *adynamia* was marked. *Capillary bronchitis* and *pleurisy* came next in order, but *cardio-vascular asthenia* and *mental alienation* had also their victims. *The nervous symptoms*, by their

intensity, became often a real complication, for we did not only notice headache, vertigo, and insomnia, but *delirium*, *coma*, *syncope*, and *fatal dyspnœa*. Among the *sequelæ* nothing was so noticeable as the *persisting cough* and the *mental and physical depression*, which in so distressing a manner, retard recovery, and so effectually predispose to relapses. *Anorexia*, *dislike for all kind of food*, *difficult digestion*, *bitterness of the mouth*, *vague muscular pains*, *palpitation* and *weak action of the heart*, have been often observed for months after the cessation of the trouble. The organs of digestion, respiration, and circulation did not recover from the state of atony and debility into which they were brought by the infectious agent, and where inflammatory lesions had impaired nerve-trunks or large centres, permanent injury or insanity followed (Woodbury).

E. *Relapses, Duration, Termination*.—*Relapses* are common, and principally due to imprudences committed during convalescence, when the system is still in that state of general debility so characteristic of this disease. In many cases they have proved fatal, for the already weakened organs have been unable to cope with exacerbated conditions or new localizations. In fact, outside of new infections, there seems to remain dormant in the system a certain quantity of morbid poison, ready to germinate under the influence of baneful causes.

Duration, variable; from 24 to 48 hours in mild cases, from 3 to 10 days in ordinary cases, and may extend to several weeks with complications.

Termination, by recovery after a few days' illness, with such critical phenomena as *sweating*, *diarrhœa*, *epistaxis*, *labial herpes*; but *convalescence* is often delayed or interrupted by relapses; *death* is always the result of complications or of exacerbated pre-existing troubles.

F. *Diagnosis*.—It is impossible to confound an epidemic of *la grippe* with anything but *dengue*. No other disease presents the same character of universality and benignity, and so short a duration when uncomplicated. Hesitation is only possible at the outset, before the disease is well established. In both we notice a sudden, rapid onset, general propagation, severe pains of equal character and location, fever of abrupt ascent and speedy evolution, short duration of the initial phenomena, gastric disturbance, cutaneous manifestations and tardy convalescence, but each presents a special constant group of symptoms sufficient to distinguish them, and these are on the one side the *respiratory localizations*, and on the other the *cuta-*

neous manifestations. The rashes of the *grip* are not constant, and it has even been asserted by high authorities that in many cases they were due to the administration of antipyrine. *Dengue*, on the other hand, is essentially an *exanthematous disease*; its rashes are of variable aspect, often polymorphous, and more frequently of the erythematous type; they persist for 3 or 4 days and more, are attended by intolerable itching, and usually followed by a desquamation which may last from 1 to 3 weeks. Many patients have often exhibited two rashes—one premonitory, the other during the course and decline of the disease. Another distinctive feature of *dengue* is the absence of any respiratory symptom worthy of our notice. The broncho-pulmonary localization of the *grip* has not been observed in *dengue*. Clinical history teaches us likewise that while *dengue* spreads from south to north, just the opposite happens with the *grip*. Even those symptoms common to both diseases present differences which should be noticed; for instance, the onset of the *grip* is not so brutal, insidious, and instantaneous as in *dengue*; the pains of *dengue* are always constant and atrocious, while those of the *grip*, although usually present, are of variable intensity; the congestive phenomena of the *grip* are sometimes partial, sometimes general, occasionally slight, at other times very marked, while those of *dengue* are limited but very intense, and especially fixed upon the nervous system and skin; the fever of the *grip* may be slight or wanting, a thing that never occurs in *dengue*, where the fever is often composed of two paroxysms and a single intermission. We must bear in mind that *ordinary catarrhal affections*, such as coryza, simple laryngitis or bronchitis, do not attack a great number of persons at a time; neither are they attended by intense nervous phenomena. Headache, dyspnœa, and prostration are paramount in the *grip*, while in simple catarrhal affections they are subordinate, and always in relation to the degree of inflammation of the mucous membrane. *Eruptive fevers* like the *grip* present a sudden onset and rapid rise of temperature; the general system is involved in both cases, and the mere appearance of a rash is not sufficient to form a diagnosis, but outside of these characters, and together with these symptoms, we have the signs belonging to the onset of each eruptive fever, namely, the rachialgia and slow pulse in *variola*, the catarrhal condition of mucous membranes in *measles*, and the special sore throat in *scarlatina*. The *thoracic form* can scarcely be confounded with *simple bronchitis*, from which it differs by the character of the cough and the fact of this being unattended by any physical sign, in the first stage. The

gastro-intestinal form presents a partial likeness of *gastric catarrh*, febrile or apyretic, and even cholera-like symptoms, but we must take into account the surrounding circumstances and the state of the forces, which are so depressed in the *grip*. Be guarded against exaggeration and the almost inevitable tendency to see the prevailing disease everywhere and to attribute to it everything.

G. *Prognosis*.—In general we may say that the *grip* in its usual forms always ends favorably, and that it only becomes a terrible scourge when complicated. Those debilitated by anterior diseases and of advanced age easily succumb to the grip. It is a disease which exerts a baneful influence on the course of pulmonary phthisis. In the statistics of England for 1890, influenza was credited directly with 4523 deaths, while the deaths from heart failure, pneumonia and phthisis, owing their origin to the grip, swelled the number to 27,000. So if we consider that the disease raged only during the first quarter of the year, and that it can have been scarcely less fatal in the following year, we are compelled to admit that it is one of the most fatal of modern epidemics. It raged with equal fatality in Germany, Austria, France, Spain and nearly all Continental Europe, and the increased death-rate in our chief American cities during its two visitations on this side of the Atlantic show that it had a wider range and has numbered more victims than any epidemic within the memory of the present generation, a fact that forcibly impresses us, in the contrast existing between the benignity of the disease and the gravity of the complications. No less noticeable is also that existing between its rapid evolution and the delay of convalescence.

H. *Pathological Anatomy*.—Hyperæmia of the laryngeal, tracheal and bronchial mucosa can be considered the only constant lesion, but in complicated cases we find inflammatory alterations of the lung pleura and myocardium, as the case may be.

I. *Treatment*.—For a disease of such variable aspect we can hardly formulate a plan of treatment. We must meet the adverse phenomena as they appear, and no one can well assert that any system is better prepared to cope with this whimsical affection than homœopathy. In general, I may say, that for the initial symptoms, as lately observed, the best indicated remedies are *merc. sol.* and *gelsemium*. The first covers the fever and catarrhal symptoms well, especially if the head, throat and larynx are the site of much suffering, the violent pains of the back and limbs are worse at night and attended by a profuse sweat without relief, and the dry, racking cough is increasing and accompanied by pleuritic stitches, soreness

down the throat and hoarseness. A febrile evolution of a remittent type, with chills along the back, languor, headache, eyeache and muscular aching in the limbs, are indicative of *gelsemium*, especially if, besides, there is vertigo, confusion of head, and inclination to lie still and rest.

Aconitum is, however, our first remedy if the inflammatory symptoms are marked with high fever, full, frequent pulse, hot, dry skin, headache, violent, shaking cough, laborious breathing and much restlessness and anxiety.

Other drugs to be considered are: *Rhus tox.*, a valuable remedy not only at the climax when the dry, tearing cough, weakness, lassitude and muscular aching are attended by erethism and the patient is compelled to move the limbs or constantly change position to find relief, but later if the typhoid state supervenes, as in individuals who being previously rheumatical become more rheumatic and complain during convalescence of a paralytic lameness which makes locomotion distressing.

Bryonia has frequently relieved the muscular or peri-articular pains, with intolerance of the slightest motion, and an easy, profuse perspiration without relief. In broncho-pulmonary and pleural localizations it is a capital remedy, especially if the cough is attended by stitching pains, splitting headache and soreness of the abdominal muscles. Obstinate constipation, vertigo and restless nights with dreams, are additional indications.

Nux vom. is indicated in irritable patients with obstinate constipation, when there is at the same time fever-heat with chilliness by the slightest motion, or if the sweat relieves the pain in the limbs; coryza with stoppage and scraping in the nose and throat; rough, fatiguing cough, causing pain in the stomach and soreness in the abdomen; dull, heavy headache with bruised feeling in the brain; rhumatized pains in the loins and large joints; cramped, convulsive muscles; a paralytic feeling of the parts and gastric complications.

Arsenicum is frequently indicated, covering as it does many of the symptoms and syndromes exhibited by various forms of the disease, such as, burning fever, with thirst, anxiety, restlessness or alternate chilliness and heat; excessive prostration and dejection, syncopal state, cardiac debility, irregular pulse, palpitations, extreme dyspnoea, neuritis, cutaneous hyperæsthesia, and nocturnal exacerbations with marked inquietude, moaning and insomnia.

Causticum has a special affinity for the nervous system, air passages and joints, parts rudely attacked by the gripal poison. In its

pathogenesis we find vertigo, restlessness, trembling, faint-like sinking of strength, flushes of heat followed by chilliness, paralytic weakness of the limbs; rheumatic and periarticular pains of a tearing, piercing character, worse at night, compelling motion but not thereby relieved; conjunctivitis, frequent sneezing, fluent coryza with pain in the chest and limbs, and great laryngeal irritation, with a dry violent hacking cough, burning rawness down the throat and trachea and hoarseness.

Pulsatilla.—I have used this remedy with good results in those cases commencing with diarrhoea, faintness and paleness of the face, where the muscular pains were of a shifting, erratic nature, and accompanied by a tired, worn-out feeling as if from fatigue. Otagia, long-lasting night cough, fleeting hoarseness, suppressed menses, pain in the uterus, fluent coryza with frontal headache and loss of taste and smell, and insomnia with nocturnal agitation are symptoms indicative of this remedy. In *aural, gastro-enteric and uterine complications* it is one of our best remedies.

Phosphorus is invaluable in *laryngeal* and *broncho-pulmonary localizations*. The larynx is dry, feels as if lined with fur, irritable and sensitive to touch, sometimes so painful that the patient dreads to talk or cough. The hoarseness is worse in the evening and after a prolonged use of the voice, may amount to complete aphonia. The cough is dry, tickling, spasmodic, with splitting headache, burning dryness of the throat, rawness of the larynx and bronchia, tearing pain under the sternum, tightness and soreness of chest and embarrassed, panting breathing, even emphysema. It covers a well developed co-existing bronchitis, and in the pneumonic evolution it is indicated in the latter part of the period of deposit, and early part of that of absorption, that is just when hepatization is coming on and just when it is going off; also when in the course of pneumonia the typhoid state supervenes.

Carbo veg., like causticum has faint-like weakness, but in attacks, also aching all over and great laryngeal irritation, with dry, spasmodic, painful cough, in violent spells, burning and soreness in the chest, great dyspnoea and a persistent hoarseness, which is worse in the evening.

Eup. perf., has intense pains in the back and limbs, as if broken, as well as hoarseness, sore throat; scraping, rough cough, soreness and oppression of the chest, flushed face, coryza and tearful eyes.

Tart. emet.—Bronchial catarrh with much rattling of mucus in the trachea, especially if there is inability to get it up. Bronchiec-

tasis. Shaking. Loose cough and oppressed breathing, relieved after the most violent efforts to cough up the mucus, and attended by anxiety, exhaustion and cold sweat. Broncho-pneumonia. Adynamia.

Euphrasia and *cepa* are important remedies in *oculo-nasal localizations*. The coryza of the former is profuse and bland, with scalding tears, aversion to light and headache, while the nasal discharge of the latter is acrid and profuse, with bland lachrymation. The principal site of distress in *euphr.* is the eyes, whose lids are inflamed and sore; in *cepa* it is the nose, and a tearing, laryngeal cough is a common concomitant. Both have sneezing and hoarseness, but only *cepa* has lameness and aching in the joints.

Belladonna and *phytolacca* are valuable drugs in the *anginose form*. In the former the throat is dry, feels raw and sore; the tonsils are bright-red, highly congested and soon become ulcerated (aphthous ulceration), and in this condition the swallowing of liquids is unbearable. The dryness may extend to the larynx and then the attacks of coughing are spasmodic and repeated, waking at night and preventing sleep. If with all these symptoms the patient becomes delirious, there is no choice to be made. In the latter the fauces are dry, rough and burning; the tonsils are enlarged, dark and ulcerated, and showing a pseudo-croupal deposit; the larynx is also dry, and burning, and the dryness excites a hacking cough, worse at night, on lying down, and followed by hoarseness and even aphonia. The angina may be attended by an acrid coryza, severe pain in the extremities and great prostration with faintness on rising. Derangement of the digestive organs is an additional indication.

Arnica is one of our neglected remedies. Its leading indications are: great sinking of strength, lassitude and sluggishness of the entire system, the patient being scarcely able to stand; the limbs ache, as if beaten, there is a pressive headache over the eyes and temples; the cough is excited by a constant tickling in the larynx and trachea, and so violent as to cause soreness of the chest, nose-bleed and even bloodshot eyes, often attended by pleuritic stitches; the sleep is disturbed either by the constant, tickling cough, or by vivid, frightful dreams. It also has tearing, tingling and numbness of the outer parts. Neuritis.

Moschus is a useful remedy when there is insomnia, due to excessive excitement of the nervous system, with great irascibility and much wailing or lamentation in consequence of the severe pains.

The cough is dry and violent, with stitching pains, constriction of the chest and paroxysms of suffocation.

Hyoscyamus has always done a good service in the dry, nocturnal, convulsive cough of laryngeal localizations, early or post-gripal, when it is worse lying and better sitting up, more especially if attended by spasms of the larynx and arrest of breathing. It is also suitable to various syndromes of the delirious form.

Sticta pulm. is a great remedy for tuberculous subjects attacked by the grip. We have no better remedy for the incessant, wearing, racking cough of this class of patients, and if we study its pathogenesis we shall find that it comprises symptoms, which could not be more characteristic of the disease in question. The patient complains of a general feeling of dulness and malaise, as when catarrh is coming on, soon followed by a painful dryness of the nose, frequent sneezing, burning of the eyelids, with soreness of the balls in closing them, and a dull, heavy pressure in forehead and root of nose. The dryness of the nose is such that the patient is compelled to blow constantly the nose to find relief, but no discharge results, and it may extend to the throat where it causes much scraping and distress. The sense of smell is gone, the appetite lost, the whole body aches (arms, fingers, joints, thighs, toes), and there is insomnia, either from nervousness, the pains, or from the cough, which soon comes to aggravate the condition. This is dry, racking, spasmodic, worse evening and night, caused by tickling in the larynx and attended by hoarseness, splitting frontal headache and oppression in the chest. If the coryza becomes moist, the secretions dry rapidly, forming scabs difficult to dislodge.

Special Indications.—For *violent fever*: Acon., bell., bryo., cham., gels., merc., eup., ars. For *violent pains*: Acon., ars., cham., coff., ign., gels., merc., rhus, puls., eup. perf. For *profuse sweat* (without relief): Bryo., chin., merc., samb., sulph.; with relief: nux v. For *weakness, with trembling* of heart: Rhus, bell., nic. ac., nux m., spig., and *anguish*: ars. For *stinging, tearing and numbness of outer parts (neuritis)*: Apis., ars., acon., plumb., sec., arn., phos., gels., arg. nit., rhus, zinc. For a *persisting dry cough*: Hyos., rumex., coni., sticta., dros., lactuta, kali b., lach., spong.; if the *cough is moist from the outset* and there is much expectoration, squilla; if the *cough is first dry and then moist with abundant expectoration*, especially in consumptives, stann.; if the *cough is dry, racking, spasmodic*, caused by a constant tickling in the larynx and attended by hoarseness, sticta; if there is *much mucus in the chest with difficult expectoration*,

ippecac., tart. emet. For *persisting hoarseness*: Carbo veg., caust., phos., hepar., dros.; *painless*: calc. carb. For *anorexia*: Ars., ant. c., nux v., nat. m., puls., verat., china., calc., arn., lach., hep., silic., sulph.

If the *typhoid state* supervenes: Rhus, gels., bapt., phos., phos. ac., mur. ac., sulph. For *coma*: Opi., lach., bell., hyos., hell., rhus, nux m. For *convulsions*: Bell., hyos., stram., ignat., cicuta, cup., cham., opi. For the *remaining weakness*: Ars., china, phos. ac., rhus., sulph. For *palpitations* during convalescence: Acon., ars., coffea, nux v., naja, mosch., tabac. For *sleeplessness*: Coffea, mosch., calc., china, lach., nux v., sepia, plat., puls., silic., sulph. For *rheumatoid pains*: Bryo., rhus, actea., caust., merc., puls., lycop. For *muscular soreness*: Arn., rhus, gels., bapt., apis. For *difficult digestion*: Am., ars., bryo., nux v., puls., carb. v., lycop., china, calc., phos., robin., sulph. For *disposition to coryza* after the grip: Silic.

Localizations.—*Oculo-nasal*: Cepa., euphr., sabad., sang., amm. carb., amm. caust., ars., ipec., sulph.

Aural: Acon., puls., cham., spig., bell., calc., china, merc., hep., silic., graph., sulph.

Laryngeal: Bell., phos., caust., carb. v., lach., sang., amm. caust., eup. perf., rumex., hyos., brom., iod., arg. nit., ars., apis, kali bich., selen., sulph.

Broncho-pulmonary: Acon., bryo., phos., tart. emet., lach., ars., sang., sulph.

Gastro-enteric: Ars., bryo., nux v., puls., merc., coloc., verat., colch., pod., phos., rhus, jatro., carb. v., china, lycop., lept., cham., aloes, calc., sulph.

Uterine: Bell., cham., puls., actea, sabin., secal., coloc., cauloph., cocc., platin., sepia, croc., lach., apis, kali carb., verat.

Forms of the disease.—*Anginose*: Bell., merc., lach., apis, phytol., nit. at., ign., lachn.

Cardiac: Acon., ars., glono., cact., lach., digit., spig., lith. carb., physos., kali carb., kalm., hyd. ac., naja., tabac., verat.

Syncopal: Acon., ars, carb. v., china, ign., nux m., cup., phos. ac., mosch., verat.

Suffocative: Bell., cup., ars., lach., samb., lactuta., spong., brom., stram., hyos., ipec., mosch., lobel., laur., naja., carbo v., verat., sulph.

Sudoral: Bryo., china, merc., dulc., samb., jabor., eup. perf., lach., lycop., sepia, graph., silic., sulph.

Somnolent: Bell., opi., lach., phos. ac., nux m., hyos., baryt., rhus, hell.; in *children*: Cham.

Delirious (vesanic): Bell., hyos., stram., ars., aur., lach., cupr., calc., opi., croc., platin., puls., staph., verat., sulph.; with *weeping*: Ign., mosch., cupr., caust.; with *rage*: Stram., hyos., bell., croc.; with *impulse to suicide*: Aur.; with *desire to murder*: Hep., hyos., ars.

As a preventive I have used with success a couple of drops of *Rubini's Tincture of Camphor* placed in the tip of fingers and inhaled before going out-doors.

METHOD.

BY CLARENCE BARTLETT, M.D., PHILADELPHIA.

(A Lecture delivered in the Introductory Course of Lectures at the Hahnemann Medical College, September 26, 1892.)

MUCH discussion there has been, and is still going on, concerning the amount of success attainable by physicians. The overcrowding of the profession is lamented, and the numerous professional failures are heralded through the land. Admitting these unfortunate facts, we have numerous thoughts for our consolation, and these show most conclusively that things are not as bad as they seem to be. There are more doctors than the people need, but is not the same true of all other established professions? Is it not true also that there are doctors and doctors; and if we single out the good from the bad, we will find that the world has plenty of room for more good ones? Instead of saying plenty of room for good ones, should I not say "a great demand" for good ones. In medicine as in other professions, and in mercantile pursuits, the man is the architect of his own fortune. If he fails, the fault lies with him and not with an unappreciative world. He may be a sincere, hard, honest worker, and yet success not crown his efforts. But there is still a reason for his failure. Lucky is the earnest man who, recognizing his lack of success, stands ready to investigate his faults and make a prompt correction of the same. I believe that every man here present has in his keeping a successful career. Yet to attain that success will require oftentimes hard work of the most trying kind.

Now, I believe that the cause of professional failure in the majority of instances is lack of methodical habits, the lack of a system in working. It is for this reason that I have announced the subject

of this lecture "Method." Method in habits, method in study, and method in thought are necessary factors in the successful man's career. In character he may be a model, he may be a most laborious student, and he may rank with the deepest thinkers of his community, and yet, without method, he becomes a rank failure, a failure made the more prominent by his many excellent qualities. After method as a factor in success comes "push." Push, without method, no matter how much we may admire the former quality, serves to make its possessor ridiculous. One might almost compare it to one of our ocean greyhounds deprived of its steering apparatus. There is an immense amount of work done, but nothing is accomplished. But given a man of method, and further let him be a man of "push," and what a combination for a successful career there is.

We have all of us been struck from time to time by the apparent helplessness of great students when a call for the practical application of their knowledge has been made. They know it all, but it is arranged within the recesses of their craniums in such a disorderly manner as to make it practically impossible to bring it forth for practical application. Such men are in pretty much the same position as the merchant who, filling his warerooms to their utmost capacity with every line of goods to meet every possible demand of his patrons, fails to arrange them so that they can be produced at call. Unless his stock is properly arranged he might as well have empty shelves. What would you think of a surgeon for whom you sent to perform a tracheotomy, if you found that he had to spend a half hour or more in getting ready because his instruments were not just where they ought to be? That half-hour's loss of time may cost a life, and the next time you want a tracheotomy done, you send for a man who can pick up his bag, put his instruments therein, and be ready to start almost as soon as you have finished explaining the exigencies of the case.

But why bother you as medical students with a discussion of the stern necessities of a professional career when for many of you the beginning is nearly three years in the future; and while, for the oldest of you, it is six months away, a six months, too, that will be marked by the hardest work of your lives? A philosopher was once asked: "How soon in a child's life should you begin its training?" He replied: "Fifty years before it is born." Following out this train of thought, I would say that the medical student should begin his training on the first day he decides to enter upon a professional career. By training, I mean the broadest acceptance of

the word, including study, habits, conduct, and in fact all that can be possibly included in all the qualities that make the successful physicians. It is not sufficient that rules of conduct and habit be thrown to the winds, while odd moments are given to "cramming" for examination. It is necessary that the student feel his dignity as such, as a future doctor. The high silk hat that nearly all of us purchased the day before commencement (ofttimes the only silk hat we ever owned), and a frock coat, do not atone for a lack of inward worth. The man must be a man. There was a time when the doctor was held in bondage, a slave to the prejudices of a community, when the silk hat, the frock coat, the gold-headed cane, the wise look, the still wiser nod, were of far more importance than his brains. Now, thanks to an increased intelligence in the community, brains and a gentlemanly bearing count for everything. The old-time doctor who could swear at his patients and get drunk at will, providing he was all right part of the day, has disappeared from the land. Or, if he still exists, he is without practice and an outcast. The old-time bondage of the doctor was well put in a number of the *Jewish Messenger* some years ago. Thus was he criticized: "If he dresses well, he thinks more of his clothes than his brains; if he does not do so, he is careless. If he goes to church, he has nothing to do; if he stays at home, he is irreligious; if he drives fast, he is doing it for show, and is hard on his beast; if he drives slow, his practice is like his driving. If he is young, he is inexperienced; if he is old, he is in his dotage. If he goes out in society, he neglects his studies; if he does not, he is unsociable." And so did the writer continue to such length that he left his poor reader to feel that there was no happiness in this world, at least for the doctor.

Student life is the time to begin the practice of those methodical habits that lead to success. But how shall we define success as applied to the life of a physician. A physician's first duty is to his patients. His second is to himself. As he succeeds in the first, he naturally should in the second. The man who cures his patients, is the one the patients want. I should define a successful physician as a man of large medical attainments, one who succeeds in attracting to himself a large clientele who will pay him fees that shall enable him to live in a style in keeping with his social position in the community.

I have said "his social position in the community." The physician's social position is the highest. His profession admits him to the thresholds of the best of the land. No potentate, no president,

no prince, is greater than the doctor. If a difference in rank ever occurs, it is when the doctor rises above others. The doctor who fails to appreciate his social status, and consort with those beneath him, can never amount to much. As a "hail fellow, well-meaning doc." he may gain a certain patronage among certain undesirable classes, but he can never attain success.

Numerous medical orators have said that the physician should be above mercenary influences. His whole thought should be for the welfare of his patient and none for his own remuneration. This doctrine is all right, if we should happen to live in millennium times, but it will give the doctor but little practical return for his labors if consistently lived up to, in these degenerate days of ingratitude. I have heard it said that the profession is degenerating simply because doctors pay more attention to their accounts than they did formerly. I believe that the doctrine that physicians should not hold their clients to a strict accounting for services rendered is demoralizing if not pauperizing to the community, and as such should not be countenanced. The financial relation between doctor and patient is a peculiar one. If the doctor restores a patient to health, the service rendered has a value that cannot be measured in dollars and cents. It is worth all the doctor charges for it, and there is still due the doctor a balance, a debt of gratitude for which the patient should hold him ever dear. On the other hand, the doctor in full recognition of these facts should not impose on a needy patient, and practise extortion. The fault, in the past, has been the desire of the doctor to avoid this latter evil, and in so doing to treat himself and his family unjustly. Carelessness in charges, carelessness in book-keeping, and carelessness in collecting, carried on through years of a useful life, have brought the doctor to the grave penniless, leaving his loved ones to battle for themselves in the midst of an ungrateful community for whom everything has been sacrificed by their caretaker.

The world does not respect a man who does not place a proper value on his services. The man who runs a "cheap John" office practice is very apt to be estimated by popular opinion on the basis he has set for himself. It is every man's duty at the very beginning of his professional life to have fixed charges, which charges must vary according to the community in which he lives, and which should be in accordance with the customs of the profession. He should make them sufficiently high to enable him to give good work in return. At the same time he should be sufficiently charitable to

depart from them at the request of those deserving of the favor. As a rule, one will find the people ready to pay for what they get. Routinism, in medical examination, consisting of a "stick out your tongue," "how do you feel," "give me your pulse," "so," and "take a powder every two hours," has existed for years, and has had a trade value placed on it by the community. For this they will pay a fixed price. A thorough investigation of every case according to recognized methods, and a manner exhibiting a love of one's profession and an interest in the case, is sure to be rewarded properly. Occasionally one meets with cranks who do not know a good thing when they see it. Let such people go. They are better let alone.

It is a bad policy for a young man to start with the idea that he can be more successful by establishing a low fee bill. As he begins so must he end. Worse than that, if he begins by cutting Dr. A's rates, what is to prevent Dr. B. from coming along five years hence, and cutting his rates in return. It only takes a few years of this sort of thing to reduce the profession to beggary. Even the club system is a bad one. Its evils do not show forth while there are but few clubs about. But when, as in England, the club system becomes wide-spread, it will come before us as a menace to professional success. Physicians who undertake work of this kind, may derive a temporary advantage therefrom, but their action in so doing will eventually do them harm personally. The recipients of their favors, do not as a rule, respect the club doctor, and do not hesitate on the occurrence of serious illness to seek aid of others.

Method in keeping accounts is an essential possessed by but few physicians. The old-time doctor, oftener than otherwise rendered bills by guesswork. Professional men would do well to take mercantile men as examples. Nothing is more important than the adoption of a proper system of bookkeeping, and method in carrying it out. Keep your books well posted, so that you can render a bill whenever asked to do so. Many a physician has lost money simply because he did his entire six months' posting just before bill time, and is unable to make out the bill just at the time the patient's gratitude is at its best, and his willingness to pay correspondingly great. If accurate accounts are essential, the prompt rendering of bills is no less so. Formerly the doctor sent in bills once a year. Then it became twice a year. The best plan undoubtedly is to render bills at as short intervals as possible. As a regular rule, at the beginning of each quarter should be the plan to follow. Departures from this are certainly in order to suit the conveniences of

individual patients concerning whose standing there can be no question. There need be no hesitation in rendering the bill. If the party is one who will be frightened by an invitation to pay, he had better be dispensed with as soon as possible.

Unsystematic accounts are an injustice to the physician's family. Should he die unexpectedly, they will be in bad shape for his executor. Even though it be possible to ravel them out, they may be uncollectable in a court of law.

If the doctor does not make himself a business man his patients will not make up for the delinquency.

I believe it to be a duty of every man, then, on starting out, to keep his books with all the system he would find necessary for a large practice. Even though his business be so small that he can carry everything in his head, he is cultivating a bad habit which will bring him to grief sooner or later.

Personal habits have much to do with a man's success. Of these, none is so important as cleanliness. Until one has watched the world awhile he has no idea how much of people's time is taken up in talking about their doctors. Some little time ago I was obliged to go out on one of our railroads to see a patient in a suburban town. It was summer time, and the ladies were coming and going in numbers. Time spent in transit did not hang heavy, for I found plenty of amusement in listening to the words of praise and criticism, justly and unjustly showered upon this or that doctor, the man with shabby or dirty clothing coming in for a full share of the criticism. "I think Drs. so-and-so and so-and-so must be relatives, because they both wear dirty collars," says one person. And another observes: "I like Dr. ——— ever so much, only I wish he would wear better clothes; the binding on his coat is all frayed out." "I should think his wife would teach him better," says another. Another lady, whose doctor approaches more nearly her ideal, says: "Dr. ——— always does me good when he enters; he looks so neat and clean." It will not take a long time to learn that dirty collars, dirty clothing, etc., do nearly as much to harm a physician as does ignorance. Untidiness will certainly preclude any possibility of a physician ever possessing himself of real estate other than that which comes to him unbidden and settles itself beneath his finger-nails.

Attention to office-hours is essential to success. Here one must begin early. Though one's waiting-room be empty most of the time, his presence during hours is essential, for he knows not at what hour his only too scanty supply of patients will present themselves. Not

only should it be a rule to be in the office, but be there promptly and leave as promptly. As I have intimated, people are not fools. If they find that a doctor's office-hours end at nine o'clock, while he hardly ever goes out until ten, they take advantage of his procrastination. And again, when he is said to return at two o'clock, they have learned to expect him at three. Of course, you say that his procrastination is so methodical that his patients regulate themselves by it. Very true; but it is a bad principle, nevertheless. I would not, of course, advise a young man to get out of his office immediately after hours unless there was reason for so doing. His duty to himself should lead him to stay about home as much as possible, to be ready for any emergency that comes along, few and far between though they be.

As to the question, what shall a young doctor do when he is not busy with his professional work? I say study, or be engaged in a healthful or dignified recreation. In no event should he find congeniality at the stables, or cigar-stores, or saloons. To see a doctor sitting on a chair on a cigar-store stoop, busily counting his thumbs, does not give the observer a high idea of his mental calibre.

A doctor who smokes to any extent must observe care in practicing the habit. To many ladies it is highly unpleasant, when ill, to have their doctor enter the room with a strong odor of tobacco-smoke clinging to them. Physicians of ability and of gentlemanly bearing have been forsaken for no other reason than their love for tobacco. Some will say smoking is all right, but chewing is bad. This is a mistake. Not that I advocate chewing, but it is possible for a man to chew tobacco and not make himself obnoxious to others, though persons of this character are very few and far between. The smoker, however, cannot help himself, and as he blows his smoke far and wide he cannot but offend the olfactory susceptibilities of others. Still, it is no more objectionable than the sight of a man with the corners of his mouth streaming with tobacco-juice, and this is the usual spectacle presented by the chewer.

One should not take up bad habits simply because some eminently successful man has them. The chances are that he did not begin with that habit. He has grown into popular esteem, and people are loath to forsake him. They will not tolerate his weaknesses in an untried man.

One learns much from the laity concerning the value of a doctor's disposition. While most of the world appreciates candor, they do not like a solemn face. I do not know where I heard the story,

but I have heard of a well-known physician sent for by one of his lady patients. Ordinarily cheerful in manner, and having the faculty of impressing that cheerfulness on his patients, he entered the room mentally pre-occupied, in a manner entirely foreign to his nature. He had been seated but a few minutes when the lady interrupted her description of her aches and pains with the remark : "Excuse me, doctor ; I see that I made a mistake ; I really did not intend to send for the undertaker." This brought the doctor to his senses, and I have no doubt the recovery of his wonted cheery manner did his patient as much good as did his medicine. While cheerfulness is a good thing, buffoonery and coarse joking are bad. They are pernicious. Even though one may be thrown with patients who appreciate that sort of wit, it is wise to refrain. Joking at the expense of the patient's ailments is exceedingly bad taste. If the patient had not thought his complaint of serious importance, he would not have called his physician's attention to it. But a cheery manner ! How valuable that is ! One must possess a confidence in his art, and in his ability to apply that art successfully, before he can attain that manner. If his patient's illness, though a serious one, is not without hope, he must indoctrinate himself with the idea that the successful result is the one he will attain. This will give him an enthusiasm in his task, an enthusiasm that will oftentimes turn failure into success. Aside from this enthusiasm there is something in a physician's manner that pleases ; that does his patients good through his mere presence. He does not always have it to the same degree. Some days he does not have it at all. Sometimes the change in him is made by the first patient on whom he calls, and the effect lasts throughout the day. At other times, it is he who is primarily at fault. Patient after patient is seen, and all are worse than they were yesterday, simply because their doctor is not the possessor of that something, call it magnetism if you will, which he had yesterday, and which he will regain to-morrow.

Method in making examinations is of the highest importance. In fact, it is necessary. Does it not occur to you that unless one is in possession of every datum on which to base an opinion that that opinion must be valueless ? First impressions go a great way. For his own welfare, if not also for the patient's, the doctor should make his examination as thorough as his knowledge will permit him to do. No means that medical science affords should be neglected. The examination should be proceeded with as if the examiner had some definite object in view. A random, purposeless asking of a

multitude of questions, first on one subject, next on another, does not give the patient confidence. The doctor should not forget that while he is examining the patient, the latter is also examining him, and likewise attempting to arrive at a diagnosis.

Here a matter pertaining to the subject of study presents itself. The most essential, excuse the expression, element in medical education is a thorough knowledge of physical exploration of the various viscera and the bodily functions. To this end, books like Flint's *Manual of Auscultation and Percussion*, Tyson *On the Urine*, Broadbent *On the Pulse*, and many others, giving as they do the significance in a clear manner of many morbid phenomena should be studied by heart. I do not mean that their words should be committed to memory. But I do mean that they should be read slowly, thought over carefully, a proper conception of the author's idea formed, and then applied in practice. Unless mental pictures of the facts expressed are made by the reader, books will avail him nothing. Many of you are masters of other languages than the English. You speak the foreign tongue fluently. In making use of it you do not first have to think out what you want to say in English and then translate it into German, French, etc., as the case may be. On the contrary, you speak it in a foreign tongue, without one thought given for the English equivalent. So it should be in medicine. Observations, symptoms, come to you as a language, translated by you at once into ideas without the intervention of reasoning or your powers of memory, but simply as an object language. As students, you see a case of conjunctivitis. You are taught to observe the presence of conjunctival injection, the absence of pericorneal injection, the lachrymation, the mucous discharge, the clear cornea, the absence of any but very slight pain. As students I say you pass through the mental process which leads you to a diagnosis after a minute inspection of the diseased eye, noting each of the morbid phenomena above mentioned. Then you reach a conclusion. The skilled oculist, on the other hand, takes a glance at the eye, and in less than a second tells you that it is a case of conjunctivitis. Just as you would say that a horse is a horse without giving any thought as to the shape of the animal, excepting possibly as it differed from other horses, so does the oculist diagnose his case of conjunctivitis. One can only attain skill in this direction after repeated opportunities for observation. In rare and complicated conditions, it is necessary to have all the rules and data for diagnosis in mind, in order to reach correct conclusions.

How shall the student study? Some say, "Let him study any way, so that he passes his examinations." No greater error ever existed. I have seen man after man who passed most creditable examinations, whose subsequent career only served to show that he attended college to get a diploma and not to prepare to be a physician. The marks that one gets at examination are not worth the paper they are written on, unless the party examined has studied with a view of self-improvement rather than that of "getting through." I have known a large number of honor men, and my experience is that the majority of them do not bear out in actual work, the promises made by their college days. Some of them are men whose brains were developed only in the direction of memory. Others are bookworms, determined to do or die, who plod along taking in everything good and bad alike, using no judgment whatever in their acquisition of knowledge. Only those have been successful who in addition to their studious habits, possessed a well-trained logical brain. While I speak thus of honor men, I can speak in the same way of men whose college days augured evil for their futures. An eminent American diagnostician succeeded in "getting through" only after more than one effort; while an eminent physiologist flunked so badly on that branch as to hurt his pride, and lead him to vow "that he would teach those fellows physiology, if he lived." Study then because you are to treat the sick. Remember the saying of Oliver Wendell Holmes that the best the doctor can do, is not too good for his patient. The study of medicine has been made more difficult than necessary in the past by the fact that text-books failed to teach disease phenomena in their clinical relations. Thus in describing pneumonia a typical case, so called, of the disease was taken, and the description based on that. Departures from the typical are then explained. In point of fact, we do not find typical cases in practice. Individual characteristics alter the type "type" to such an extent as to make the clinical features of the case almost unrecognizable, from the book description. Practically, the student studies the disease from one standpoint, while in practice, he views it from an exactly opposite one. It is as if one approached the college building from down Broad Street, and subsequently approached it from the opposite direction. The pictures presented from each point of view are entirely different. There is but one way of becoming a thorough clinician, and that is by studying the significance of symptoms. By any other path, one becomes a mere routinist. To be exact, a diagnosis does

not consist of giving a name to the patient's disease. I can say that a case is one of typhoid fever, or locomotor ataxia, but I give no conception of the features of this particular case to a learned physician. It may satisfy the patient and his friends, but it should never satisfy the diagnoser. To the name typhoid fever or locomotor ataxia, one must add a description of the phenomena that make the case different from the recognized types, or the significance of the same.

This method of study is perhaps the only one that is at all applicable to neurology. In the application of the cerebral anatomy and physiology to cerebral localization, we are simply adding common sense to our knowledge of anatomy and physiology. The study of medicine by tracking symptoms to their causes is comparatively new. Text-books with this object in view have been prepared only within the late decade. Many prominent clinicians have taught the method in bedside instruction; but as that form of instruction is necessarily limited, students have not had full opportunities of applying the method. Practical men in all walks of life have adopted the method, in tracking effects back to their causes, following out clues, one might call it. Some years ago I was much interested on reading a short item in the *Medical Record* entitled "Horse-sense in Diagnosis." It was as follows:

"We commend the following item to such as are often unable to make a diagnosis in apparently obscure cases."

About two miles from town he suddenly checked his horse, gazed intently on the ground, and said: "Some fellow has lost his saddle horse, here this morning."

There was no advertisement on any of the trees offering a reward for a lost horse, and as there was no lost horse in sight, we were at a loss to understand how, if a horse was lost, our friend could know so much about it.

The doctor inquired: "How do you know that a horse has been lost?"

"I see his tracks."

"Are there not hundreds of horses pasturing on the prairie, and how do you know that this is not the track of one of them?"

"Because he is shod, and the horses herding on the prairies do not wear shoes."

"How do you know that he is a saddle horse, and lost?"

"I see a rope track alongside his trail; the horse has a saddle on, and the rope hangs from the horn of the saddle."

"But why may he not have been a horse that some has ridden over this way this morning, and why do you insist that he is lost?"

"Because if a man had been on his back, he would ridden him in a straight course, but this horse has moved from side to side on the road as he strolled along, and that is a plain sign that he grazed as he went, and that he had no rider."

"After that," said the doctor, "it would not surprise me if you tell us the horse's age, and the name of his owner."

"Well that would not be very hard to do. There are signs that have told me the owner's name, and there are other signs that if I had time to examine would tell me his age. I know he is one of old man Prendergast's horses. Prendergast has a large bunch of horses down in the bottom, and an old nigger down there does all his shoeing, and shoes no other horses except his. So we know his shoe track, just the same as we know his brand."

After this conviction on circumstantial evidence it would not seem extraordinary if the remnant had given us his opinion of the life and character of our great-grandmothers, drawing his conclusions from an examination of some of our physical peculiarities.

The above appeared in the *Record* September 2, 1882, and was excerpted from *Texas Shiftings*.

Of more recent date is a lecture by Dr. T. Lauder Brunton on the "Method of Zadig Medicine." It appeared in the *British Medical Journal* and *Lancet*, simultaneously under date of January 2, 1892. As food for thought I consider that no man can consider his medical education complete without having read this lecture. As food for thought, as interesting reading matter, it is without an equal. The text of the lecture is the story of Zadig, and the importance of tracking symptoms to their causes, the application of Zadig's method to medicine in other words. Brunton was not the first, however, to start this line of thought in medicine however, for we find it foreshadowed in DaCosta's wonderful work on *Diagnosis*, a book that one admires the more, the older he grows, and the better posted he becomes.

To the story of Zadig:

"Zadig was a young man who, disgusted with life, retired from Babylon to a lonely place on the banks of the Euphrates, and there studied animals and plants until he saw a thousand differences where others could see only uniformity. One day one of the queen's eunuchs, followed by a band of officials, came hastening past, and asked Zadig, 'Have you seen the queen's dog?' Zadig modestly answered, 'A bitch, I think, not a dog.' 'Quite right,' said the

eunuch, and Zadig continued: 'A very small spaniel, has lately had puppies, limps with the left fore foot, and has very long ears.' 'You have seen her, then,' said the eunuch. 'No,' said Zadig: 'I have never seen her, and did not even know that the queen had a dog at all.' At the same time the finest horse in the king's stables ran away, and the chief huntsman, in seeking it, also made inquiries of Zadig, who said, 'A first-rate galloper, five feet high, small hoofed, tail three feet and a half long; cheek-pieces of the bit are of twenty-three carat gold and the shoes silver.' 'Where is he?' cried the chief huntsman. 'I have not seen him, and never heard of him before,' said Zadig. Naturally enough he was suspected of having stolen both the spaniel and the horse, was tried and condemned; but no sooner was sentence pronounced than both the missing animals were found. Zadig was then asked to explain how he knew so much about them without having seen them, and this he said was the way: He noticed one day in the sand the tracks of an animal which he easily recognized as those of a small dog. Long faint streaks on the ridges of sand between the footprints indicated that it was a bitch with pendent dugs, showing that she had had puppies shortly before. Other marks on the surface of the sand close to the prints of the fore feet indicated that she had very long ears, and one of the footprints being fainter than the others showed that she was slightly lame. As for the horse, the marks of his hoofs were all equidistant, showing that he was a famous galloper. In a narrow alley the dust on the trunks of the trees was disturbed at three feet and a half from the middle of the path; this showed the length of his tail, which had swept the trees as he lashed it from side to side. Branches of the trees met overhead at a height of five feet, and under them were some newly-fallen leaves, showing that the horse had brushed against them and was therefore five feet high. As to his bit, he had rubbed it against a stone which Zadig recognized as a touchstone, and his shoes had left such marks upon pebbles of another kind as showed that they were made of fine silver."

A story very like that of Zadig is told of an old Fakir in the Syrian Desert. He was one day visited by several Arabs, who asked him whether he had seen their lost camel. "It was very tall," said the Fakir, "it was blind of the right eye, it had lost one of its front teeth, and it was laden on the one side with honey and on the other with corn." "Yes," said the Arabs, "that is exactly the camel; you have mentioned every point about it. Where is it?" "I have never seen your camel," said the Fakir. "But, if you have not seen it," said the Arabs, "how can you know all about it?" "I

knew that it was a very tall camel, because the tracks of its steps in the sand were further apart than those of an ordinary-sized camel. I knew it was blind of the right eye, because it had cropped the herbage only on its left side; and I knew that it had lost one of its front teeth, because in the middle of every bite that it had taken there was a small uncut part corresponding to where the tooth ought to have been. I knew that it had been loaded with honey on the one side and with corn on the other, because I saw flies buzzing round one side of the track and ants busy on the other carrying away grains of corn that had fallen from the load."

An interesting case of application of Zadig's method to medicine is quoted by Dr. Brunton, from the late Dr. Milner Fothergill. It is as follows:

"In the town of Leeds there once lived a quack who had received no professional instruction whatever, but was known far and wide for his wonderful cures and especially for his powers of diagnosing the diseases of patients whom he had never seen by simply examining their urine. A celebrated surgeon, Mr. X., wishing to see his method of working, desired to be present one day, and the quack readily acceded to his request, feeling much flattered that so great a man should patronize him. Shortly after Mr. X. had taken his seat a woman came in with a bottle of urine, which she handed to the quack. He looked at her, then at the bottle, held it up between him and the light, shook it, and said: 'Your husband's?' 'Yes, sir.' 'He is a good deal older than you?' 'Yes, sir.' 'He is a tailor?' 'Yes, sir.' 'He lives at S.?' 'Yes, sir.' 'His bowels are obstinate?' 'Yes, sir.' 'Here,' he said, handing her a box of pills, 'tell him to take one of these pills every night for a week, and a big drink of cold water every morning, and he will soon be all right.' No sooner had the woman gone out than Mr. X. turned to the quack curious to know how he had made out all this. 'Well, you see,' said the quack, 'she was a young woman, and looked well and strong, and I guessed the water was not her's. I saw she had a wedding ring on her finger, so I knew she was married, and I thought the chances were it was her husband's water. If he had been about the same age it was hardly likely that he was going to be ill either, so I guessed he was older. I knew he was a tailor because the bottle was stopped, not with a cork, but with a bit of paper rolled up and tied round with a thread in a way that no one but a tailor could have done it. Tailors get no exercise, and consequently they are all very apt to be constipated. I was quite sure that he was no exception to the rule, and so I gave him opening pills.' 'But how did

you know she came from S.?' 'Oh, Mr. X., have you lived so long in Leeds, and don't know the color of S. clay? It was the first thing I saw on her boots, the moment she came in.'

A smart quack surely; one probably with far greater natural attainments than many legalized physicians. Evidently of higher order than another quack of whom I was told, and who diagnosed his patient's cases without asking the patient a question.

The story as told to me ran thus:

"A man said that he never had so much fun as when he travelled as an auxiliary to a quack doctor. They arrived at a town and had themselves announced. The 'auxiliary' remained in the office while the doctor was safely placed behind a screen. A patient came in, met the auxiliary, who explained that the doctor would be in in about five minutes; would not the visitor take a seat, etc. Then he proceeded to engage the patient in conversation for the benefit of the 'fake' back of the screen. Sufficient information for all practical purposes having been obtained, the fake rushed into the room, laid aside his whip, overcoat and hat, and proceeded to tell the patient his symptoms without more ado, and then to diagnose the case as tape-worm. This worm he forthwith proceeded to remove by another swindle at an enormous price."

And still another example of the method of Zadig from the experience of Dr. Brunton himself:

"I remember, on one occasion, being consulted by a gentleman who was second in command in a department involving not only heavy work but great worry. He was suffering from dyspepsia, and looked thin and worn. I examined him most carefully, and could find absolutely no cause for his symptoms. Knowing, however, the conditions under which he was working, I said to him, 'How is your chief?' 'He is not well.' 'Is he irritable?' 'Yes, very.' 'Who is physicking him?' 'Dr. So-and-So.' I returned him his fee and said, 'Go to Dr. So-and-So, and tell him to physic your chief; it is no use for me to try to cure you with medicine.' I met my patient some time afterwards, who, with a sly glance at his chief, whispered to me, 'Your prescription was very efficacious.'"

I have in the above endeavored to show you the importance of methods in the attainment of success in medicine. I have not by any means exhausted the subject. In placing method as a matter of so great importance, I do not wish to undervalue work. Work is necessary, and method must be added to it to make it efficient.

As to failures among medical men, I believe they are all preventable. Most of them are due to lack of method. Some are the re-

sult of chronic dissatisfaction which characterizes many men. Dissatisfaction drives them into medicine and dissatisfaction drives them out of it. Medicine is the gainer the last time only.

Some fail from lack of perseverance. It is a universally recognized fact that a practice having been once obtained, it affords the possessor a return that comes in year after year with almost the regularity of a definite income. It is this very fact that makes a foothold so difficult to obtain. People are not very willing to forsake the old for the new, nor is it to be expected that they will do so. Many and many a successful man has despaired in the beginning. The great Sir Astley Cooper made but five pounds his first year, and the beloved Agnew once abandoned medicine in disgust, and went to keeping a country store in Chester county. Both men became the most eminent surgeons of their respective periods. If, therefore, you do not at once succeed, keep at it. The time will come when you will be on top, providing you pursue method in every step.

A CASE OF RETAINED PESSARY.

THIS morning I was called upon to see an old lady, aged 77, complaining of pruritus over the back and inability to reach a vessel to void her urine when the desire came; her previous history showed prolapsus of the uterus, and about nine years ago a pessary was placed in position to support the womb; the pessary had not been disturbed in that time. A few years back her legs gave way suddenly from under her, since which time there has been a paretic condition of those members, but she is able to get about the house; otherwise she is in a fairly good condition considering her age. I made a digital examination of the vagina and found a large Hodge pessary lying loosely within. I attempted to withdraw it, and partly succeeded, when it would not come any farther, and caused some pain. Upon inspection discovered the posterior lip of the cervix had curved backward around the posterior part of the pessary; inflammation must have been set up and adhesions to the posterior wall of the cervix had taken place, thereby forming a fibrous band around the end of the pessary about an inch wide and nearly a half inch thick. To remove this pessary it was necessary to cut this band, which was done; the tissue was tough and of a fibrous nature, audibly gritting under the knife edge.

Fraternally yours,

CHAS. A. AYERS, M.D.

WILKES-BARRE, PA., December 18, 1892.

EDITORIAL.

MEDICAL QUARRELS.

QUARRELLING among professional men is proverbial. Clergymen, physicians, and lawyers alike seem to possess combativeness as a strong characteristic. Unfortunately, the two professions based on the highest moral ground, those of medicine and theology, are the ones in which warfare having arisen, becomes the most bitter and persistent. Example is not taken of the lawyers' method, bitter enemies in court, and the best of friends outside. Very few bitter medical quarrels have their original inception from any than a trivial cause. Some forbearance in the beginning on the part of one of the combatants, or possibly an endeavor on his part to secure a correct interpretation of the other's ideas, would have nipped the affair in the bud.

We believe that medical journals should adopt a well-defined policy regarding these unfortunate occurrences, and that policy is silence. This was outlined in the policy of the *HAHNEMANNIAN MONTHLY*, when it first came under its present management, in 1888, and we believe has had much to do with the success of the journal since that time. The publication of various unpleasantnesses with attention to "gossipy" detail may make very interesting reading, and enable the reader to while away an idle hour, but it neither ennobles his mind, or increases his respect for his belligerent brethren. If the "row" happens to be a bitter and famous one, many readers may be secured to the magazine publishing the reports of the same, but a revulsion of feeling will come sooner or later. It is therefore very short-sighted policy for an editor to play the part of demagogue and endeavor to work to his own advantage by calling forth all that is base in the feelings of his readers. The policy of silence serves as a well-merited rebuke to the combatants, and is hurtful to their pride. The funny paragrapher of the daily press has started on its journey an anecdote concerning a prominent man who complained to Oscar Wilde of the way the newspapers were abusing him. To this the æsthetic one replied in a way showing that he knew whereof he spoke, that it was nothing like as bad as being ignored.

Aside from the question of policy, the wide-spread publication of a disturbance goes far towards preventing a return to peace. Man

is proud, and sensitive to ridicule. To have it published to the world that he and so-and-so quarrelled but are now friends makes him feel that he has forfeited some self-respect. Indeed he may be twitted by acquaintances over the outcome of the trouble. If, on the other hand, the quarrel is known to but a few, this barrier to peace does not exist, and the question can easily be settled on its merits.

Many, in fact most quarrels, appear on their face to have had their existence on principle; but as they grow older, and more bitter, support of principles is thrown to the winds, and personality and vituperation become the weapons of warfare. One is here reminded of the bitter code-fight in the New York Academy of Medicine several years ago. Originally, there was a discussion as to the adoption of the new code of ethics, in which the "old codists" were overwhelmingly defeated. The vanquished then proceeded to institute measures to regain by subtle means that which they failed to secure in open honorable combat, and the resulting "fracas" stands as a disgrace to American medicine, although the conspirators failed in their purpose.

We believe that quarrelling will become a lost art among doctors, if certain facts are clearly borne in mind. In the first place, it should be remembered that the majority of men are moved by good intent in all their actions. Thoughtless they may be frequently; indeed they are thoughtless very frequently. Inasmuch as this is a fault of the many, each one of us should be ready to place the proper construction on the thoughtlessness, and not dignify it by becoming angry. Then in the second place, a thoughtless action wounds the feelings of a hypersensitive person; and another element is introduced. Cannot most of our readers recall instances in which a thoughtless though well-intended action on their part has wounded the sensibilities of friends? We can recall any number of affairs where imaginary grievances were held by the self-alleged victims, in which the aggressor was in blissful ignorance of any trouble whatever. Cases of this kind find a ready remedy in candor. No self-respect is lost in demanding an explanation. If the explanation is satisfactory, the quarrel is averted; if it is not, then the offended one finds the grounds for his wounded feeling stronger; but in seeking this explanation, application should be made solely to headquarters.

Men can be friends though differing respecting principles. Indeed, we must say that men should be friends despite irreconcilable

differences in principle. Especially is this true respecting medicine. The greatest tolerance of the opinions of others is the strongest evidence of an enlightened mind. Intolerance is symbolic of savagery. The discussion of principles is always in order. By discussion only can scientific progress be made. But there are such things as "discussion" and "discussion." In one, logic and facts form the material; in the other, false logic, pseudo-facts, wit, sarcasm, irony and sophistry, seek to strengthen what is otherwise an untenable position. Very few take umbrage at an open, plain, straightforward argument, no matter how iconoclastic it may be to their pet theories. When, however, the would-be logician attempts to be funny, perverts the meaning of his adversary by bringing to his aid all the well-worn devices of false argument, possibly adopting the lawyer's advice to abuse the plaintiff's counsel when the case is a weak one, a quarrel is imminent. We pick up a medical journal and read a well-written article in which the author advances certain ideas, which antagonize those of a writer of the month before. In fact, they show conclusively that the first man was in error. Instead of being grateful for his enlightenment, the first man comes forward the next month with another article in which he dodges the question entirely, forgets the principles involved, and goes off into all sorts of side-issues. This picture is unfortunately too common.

There are some men of sterling qualities with whom differences of opinion, even in questions involving principles, on the part of friends, are sufficient to engender bad feelings. No more serious error ever existed. Principles should always be respected. The man who holds fast to them is all the more a man.

An unfortunate attribute of humanity is a distaste for reading views not in accordance with their own. This is shown in the political world by the steadfastness with which the Republican and Democrat clings to the organ of his respective faith, ignoring completely all others. Such a course does not permit of a high degree of development. Mental friction is necessary to improvement; and mental friction cannot be obtained until one meets views opposed to his own. The desire innate with humanity for "abdominal massage" should be downed. The remedy is a good one for cross, colicky infants, but is not indicated in adults in anger. It may suppress the bad emotions for a time; but it is a suppression only. It does not work a cure.

The repetition of innocent remarks often brings trouble. Many and many a remark, when made in the first place, was called forth

in a certain connection, which robs it of all personality. But separated from other portions of the conversation gives rise to entirely erroneous views respecting its author's intent. This is a point well worth bearing in mind.

Quarrelling may sometimes be a necessity, but it need never proceed beyond the point of agreeing to disagree and separate. When it reaches the point that the one side seeks revenge as a means of getting even with the other, it becomes a subject for the contempt of all right meaning men. When this stage is reached, the original *casus belli* is probably lost sight of, and the combatants only, and not their views, are before one.

We have penned these lines with no particular case in view, but rather as an expression of our own ideas and feelings, as we read in the daily papers from time to time of the bickerings and disseussions in professional life. Hardly a month passes by without the press bringing to us an account of a doctor's quarrel in this or that city. And how the mind of the lay editor, demagogic as he is, gloats over the affair, and how he moralizes! And such headlines as he gives the "row" a prominent place on the first page of his "sheet!" And how edifying such publicity is to the participants!

Let us so regulate our course as to do all in our power to kill the old-time superstition regarding the intolerance, illiberality, and hostility of the medical profession towards each other.

MEDICAL LEGISLATION AGAIN.

THE *Pittsburgh Medical Review* is nothing if not orthodox. Its orthodoxy is worthy of the most conservative of Philadelphia's bluest blood. Its December number exhorts the worthy followers of light in the Commonwealth of Pennsylvania to rally to the support of a medical examiners' bill, which any one having the least idea of justice must know at a glance should not be entertained seriously for a moment. "The text of the bill prepared for the coming session of the legislature differs in one essential only from that which was unsuccessfully advocated last year. This is in the omission of materia medica and therapeutics and the principles of medicine from the list of subjects in which applicants are to be examined." "The proposed bill is not such an one (*sic*) as the regular profession would desire, nor what strict adherence to all that is

best from a humanitarian standpoint would demand, but when the State recognizes educational institutions of sectarian medicine it cannot withhold recognition of their graduates under the laws regulating practice."

The above quotation shows the animus of the *Review* towards homœopathy. Its editors are candid enough to admit that they only show homœopaths the slightest recognition because they are obliged to do so. In the November number they expressed their sorrow that Mrs. Harrison was treated by a homœopathic physician, thus frittering a valuable life away; though candor led them to add that she would probably have died as soon under orthodox methods. The fact that men of such bigoted views advocate the bill is an all-sufficient reason for opposing it. Let all our readers appeal to their respective representatives in the legislature and secure their opposition to the bill.

STATE INSANE ACCOMMODATIONS.

THE time is fast approaching for the convening of the Legislatures of the States of Pennsylvania, Ohio, Maryland and New Jersey. In each of these States there is no adequate provision—probably none at all—for the insane citizen for whom homœopathic treatment is desired. The members of these Legislatures will make no effort to correct this evil unless their attention is personally directed to the situation by those directly interested, and it now becomes the plain duty of each and every homœopathic physician to make a systematic, individual and united appeal to their Legislature for the establishment of an insane asylum to be under the sole care of physicians of the homœopathic school. The State has no right to shower an abundance of care and provision upon one class of her citizens, and at the same time ignore her duty to those of another class. Legislators are almost invariably fair minded, honest and free from medical prejudices. They recognize the claims of all classes of citizens, and when they comprehend that previous legislation has established a state medicine, they will be perfectly willing to extend equal protection and privileges to all classes. Homœopaths have no desire or intention to deprive allopathic physicians of their just dues, but they do intend to put a stop to the present unjust monopoly of state medical appointments.

GLEANINGS.

GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D., AND FRANK H. PRITCHARD, M.D.

AORTITIS.—Dr. Henri Huchard is at present holding a series of clinical lectures on the various forms of aortitis. The symptoms arise from the dilatation of the aorta, the endo-aortitis, the obliteration or stenosis of the valves and the propagation of the inflammation to the neighboring organs, peri-aortitis.

The aorta should be percussed at the second intercostal space. It should not extend beyond the right border of the sternum, hence, if there be dulness beyond the sternum into the second right intercostal space, then one may affirm the existence of aortic dilatation. The patient should sit, leaning slightly forward in order to approach the aorta to the sternal wall. One is not to percuss with the patient in the dorsal position. No pleximeter is required, as the sternum itself is a veritable pleximeter. The subclavian arteries are found to be situated higher up in the neck than in the normal state. The right one should be sought for, as it is more accessible than the left. Lower the shoulder and carry it backwards. This artery is situated behind the tubercle of the scalenus anticus. These two symptoms, together with the presence of abnormal beating of the arteries of the neck are characteristic of aortitis. This latter symptom, though not present invariably, is of importance. It is found only in three diseases: exophthalmic goitre, pericarditis, aortic affections and, sometimes, in chlorosis. When present, a diagnosis should be made by elimination. Under the influence of the dilatation an insufficiency of the sigmoid valves may develop. The murmur is soft and not always present, while in valvular insufficiency from anatomical alterations the characteristics are different and the bruit is permanent.

When the endo-aortitis implicates the openings of the coronary arteries, peri-coronary aortitis, it gives rise to the symptoms of angina, which are both frequent and grave. In chronic aortitis, acute secondary aortitis, following chronic aortitis, with chronic aortitis, with dilatation of the aorta and subclavicular arteries, there may appear in the arms, forearms and hands severe neuralgic pains, which, sometimes extending into the thoracic wall, impress one as angina pectoris, especially when they appear paroxysmally and are associated with violent palpitation. These are explained by the impinging of the displaced subclavian arteries upon the branches of the brachial plexus. The pulsating arteries press on the nerves and produce these pains. Therefore the patients complain of pains in one or both shoulders and palpitation, accompanied by pain in the upper and anterior portion of the chest, internal sides of the arms and forearms. After a full meal the patient may be seized with terrifically painful neuralgic attacks, violent palpitation, the pulse going up to 116 or 120 per minute, while lancinating and tearing pains course through the arm and forearm, accompanied by intolerable formication in the hands. The pectoral region is also the seat of similar painful symptoms. The murmur may be absent in both acute and chronic aortitis when the inflammation is limited to the arch, or does not involve the aortic orifice. But the timbre of the normal sounds of the base are altered. They are more or less veiled, and as if dulled or stuffy. When extensive it may diminish the elasticity of the aorta, which is revealed by prolongation of the systole. It may appear as a double sound, bruit de trot, galloping sound, or by a prolonged sensation of shock in the præcordium, the diastole being diminished. In the last stage of the disease a murmur may be perceived in the tricuspid valve, being heard at the xiphoid appendix. From the increased effort required to supply the aid lost from the lack of elasticity in the aortic walls the heart undergoes hypertrophy, even in the early stages of the disease. Oedema of the lower limbs then sets in, to increase in a few days to great proportions, invading, successively, the thighs, trunk and walls of the abdomen. At the

end, large quantities of urea are found in the urine, and in one case true anasarca appeared. The symptomatology of the affection is not limited to the heart and aorta but extends over the whole arterial system. The face of the patient assumes a leaden, anæmic, waxy and earthy appearance. He suffers from attacks of paleness, local coldness, and plaques of local ischemia in different parts of the body show themselves, the pulse, before then variable, becomes weak or concentrated, or attacks of cerebral ischæmia set in, with vertigo, fainting, etc. In acute aortitis one may meet with symptom complexes that simulate aneurism. The pulse is unequal, appreciable to palpation, but sometimes only to the sphygmograph. In such patients both radial pulses are to be examined, for if there is a tendency to obliteration of one of the subclaviculars, there will be seen a lack of isochronism between the two radial pulses. Under such circumstances an aortic aneurism may be diagnosed when it does not exist. The peri-coronary aortitis determines an ischemia of the heart muscle, which is made manifest by an attack of angina pectoris, one of the most frequent and grave complications of acute or chronic aortitis. In cases of more extensive and generalized aortitis, symptoms are observed that indicate an obliteration of the celiac trunk, renal arteries, as well as those running to the mesentery, bronchi and even the intercostals, are affected. To affection of the latter is the painful dyspnœa and respiratory insufficiency to be attributed. Albuminuria, in certain cases, is due to the same cause, while in others it is from the development of an interstitial nephritis, in the frequent cases where acute aortitis appears in the course of arterio-sclerosis and arterial atheroma. More rarely it is due to an embolism of the renal artery. Asystolia is still another cause. To this latter are to be ascribed the local ischæmia and the characteristic face of the patient. The face is terribly pale, by starts assuming a leaden or earthy appearance, which, with the expression of terror and anguish, give their physiognomy a special type; if the disease is generalized the blood-stream is lessened, the patient emaciates quite rapidly, masses of muscle fading away, and he presenting a true arterial cachexia. The inflammation may extend to neighboring organs, peri-aortitis. There are two sorts of painful symptoms coming under this portion of the symptomatology: Painful symptoms, chiefly transient, from partial obliteration of the coronary arteries, and permanent painful symptoms, produced by extension of the inflammation to the pericardium, the nerves of the cardiac plexus and even to the pleura. These are often devoid of any attacks of anguish, and are increased by pressure upon the phrenic nerves. They have been wrongly confounded by certain authors with true angina pectoris. But besides these there are certain dyspnœic and painful manifestations, showing that arterial, and especially aortic diseases, are often early and nearly always painful affections. In this they differ from heart diseases. The patients complain of a sensation of weight, heaviness, fulness, tension, constriction of the epigastrium and base of the thorax. Or there is a feeling of oppression, of retro-sternal tearing or burning, sometimes of lancinating pains running through the chest, from anterior-posteriorly. Often the painful anxiety is accompanied by a sensation as if a bar were across the chest and of thoracic constriction, with pains irradiating into the neighboring organs; the shoulder, neck, larynx, œsophagus, back, lateral portions of the spinal column, or they may be confounded with rheumatic pains. The writer has not long since seen a patient who had been under treatment for rheumatism of the scapulo-humeral articulations and shoulders, that turned out to be suffering from aortitis, with radiation of the pains. The œsophagus may be affected, dysphagia, or a disturbance observed like the globus hystericus, a sort of hydrophobic pericarditis. In the hepatic region the pains may simulate hepatic colic, of which the writer has seen any number of examples. In the stomach pseudo-gastralgic attacks have been observed. These pseudo-neuralgias of various organs are peculiar to aortic affections and are of diagnostic value. Other painful manifestations are seen in the intercostal and phrenic nerves. Pericarditis sicca has also been observed as a complication. Here the slight febrile movement should not be attributed to the aortitis, for this affection is febrile, but to the pericarditis. One should be careful not to regard the pericarditis as the only disease present. This febrile movement is accompanied by palpitation, attacks of tachycardia, without fever, the pulse sometimes running up to 120 to 140 pulsations per minute. Others will be seen where the pulse-rate falls to 50 to 60 per minute.—*Le Progrès Médical*, No. 41, 1892.

CONGESTIONS OF THE LIVER AND THEIR TREATMENT.—Prof. Dujardin-Beaumez considered this subject in a lecture, held at the Hospital Cochin, Paris. In

the symptomatology of congestions of the liver an augmentation in size is the most important sign. Percussion is inferior to palpation in determining the size of this organ. Glenard's procedure is the best method outlining it. It is, in short, as follows: The physician seats himself on the bed of the patient, most always on the right side, with his face to the patient. The left hand grasps the hypochondrium of the patient, the fingers being posteriorly and the thumb in front. With the fingers one tries to force the liver forwards, while with the right hand on the median line the right hypochondrium is rendered immovable. At the same time the patient should make efforts at deep breathing, thus lowering the organ with each inspiration. In some cases there are accompanying painful symptoms, as lancinating pains, stitches, a feeling of distress, and a painful sensation on taking a deep breath. At the same time there is drawing or constriction in the thorax, on a level with the xiphoid appendix, when the patient assumes certain positions. These symptoms are due to the hepatitis which so frequently accompanies such congestions. The resultant adhesions which form give rise to sensations of constriction in the chest, especially when the liver begins to resume its normal proportions. The urine also undergoes important modifications. One cannot affirm the presence of hepatic congestion without the appearance of urobiline and sometimes also of bilirubine in the urine. This is associated with a modification of the complexion, the eyes become slightly yellowish tinged, as well as the mucous membranes. Sometimes there is an actual icterus to be observed, but the color is usually subicteric and progressing as an accompaniment of hepatic congestions. These three great and capital symptoms are accompanied by febrile symptoms. Monnerett has insisted upon the existence of an intermittent type as well as a remittent type in the febrile phenomena of hepatic congestion. This, according to him is a characteristic sign of these congestions. This is not wholly true, although there is a frequent association of febrile symptoms with hepatic congestion. Sometimes these attacks assume a great gravity, similar to attacks of pernicious fever. The spleen is increased in volume, symptoms of disturbance of the portal vein appear, as hæmorrhoids. The heart may be disturbed and the stomach being altered in its functions there results a faulty state of nutrition, with rapid emaciation and a very notable weakening of the strength. Certain hæmorrhages are apt to follow, especially epistaxis, and become quite rebellious to treatment.

Hepatic congestions may be divided into several varieties:

1. Congestions of gastro-intestinal origin.
2. Congestions of infectious origin.
3. Diathetic congestions.
4. Congestions of mechanical origin, of which the congestion of various heart diseases is an example, *le foie cardiaque*.

The congestions of gastro-intestinal origin are the most interesting. There are admitted three subdivisions; congestions of purely alimentary origin, as from too exciting foods, badly chewed foods, alcohol, etc.; congestions due to toxines, from the digestive tract or the foods themselves and those from poisoning, as lead, arsenic, phosphorus, etc.

One of the most frequent causes is excessive eating. Great eaters and excessive drinkers are liable to attacks. In countries where there are great eaters, as in Germany, Russia, and the North of France, it is frequently seen. Persons from large cities who visit the seashore, and developing an enormous appetite, indulge too freely in eating, will be especially liable to this affection, especially from indulging in fish or shell fish. These may be said to be the rule when a high temperature prevails. Rapid eating produces an inclination to gastro-duodenitis and secondarily to hepatic congestion. All liquids introduced in the digestive tract are absorbed by the radicles of the portal vein and traverse the liver. Thus such poisons as lead, copper, arsenic, etc., localize themselves in the liver and determine either transient or chronic congestions. Congestions from toxines belong in this same subdivision. Decayed fish, tainted game, canned lobsters, that have begun to decay, sometimes cause a very intense and grave congestion of this organ. Imperfect digestion, producing putrid products that are absorbed and reach the liver give rise to such a condition. Especially the intestine, in the production of fæces, may form toxines that are easily absorbed, and make up the complex of pathological symptoms called by Bouchard *stercouremia*. This is hastened by the presence of ulcers and the destruction of epithelium, for, it is known that in dysentery the ulcerations in the colon are the point of departure, not only of the congestions but also suppurative hepatitis. Recently the attention of the profession has been called to the connection

between hepatic congestion and dilation of the large intestines as well as arthritic and nervous states, associated with pseudo-membranous colitis. Hepatic congestion is seen in infectious diseases, indeed, the majority of the infectious diseases may be associated with congestions of the liver. Typhoid fever is an excellent example of an infectious disease, with ulcers of the intestine, hepatic congestion and a special microbe. Certain diseases are often associated with hepatic congestions, as the arthritic and herpetic. In the last group there is that affection, so frequent in heart patients, mechanical congestion of the liver. Affections of the right heart are most frequently associated with this form. In tricuspidian affections it is the rule, but it is also true of the left ventricle. All asystolic patients have this sub-icteric coloration of the face, with a feeling of heaviness and pain in the hepatic region. Pressure in the right hypochondrium causes pain. In the treatment, the disease being always of a secondary nature, the hyperæmia is first treated by revulsion, hydrotherapeutics used with care, as too active douching will increase the congestion, rectal irrigation. He denies that there are remedies having a direct decongestive action upon the liver (?). Prescribe milk, eggs, starchy foods, green vegetables, and fruits. If meat is given, avoid underdone meats. The crust of the bread is to be preferred. As a drink milk or a little white wine. This is the treatment of the active congestions. As to the passive congestions, the heart must be the point of attack, for it is the weakness of its contractions that cause the venous stasis. All heart tonics are indicated. Digitaline, the French variety, at one milligram per diem, is an excellent tonic to the heart. Strophanthus is also of great service, five drops twice a day. Potain advises an exclusive milk diet.—*Le Bulletin Médical*, No. 82, 1892.

THE TYPHOID FORM OF THE GRIPPE.—Professor Lemoine, of Lille, in a lecture at the Hôpital de la Charité, of that city, divided the numerous clinical manifestations of the grippe into three classes, the thoracic, abdominal and the nervous forms, each again undergoing various modifications. The abdominal form may be characterized by disturbances of the digestive tract, disordered digestion, now resembling that of an infectious disease and again not so severe. In some epidemics it may appear as a dysentery or with choleric symptoms. There are also cases where the disease may appear with the stamp of typhoid fever and be accompanied by abdominal symptoms and ataxo-dynamical phenomena. A number of such cases have recently come under the observation of the lecturer during the epidemic of 1891, and a differential diagnosis was only possible from a careful study of the disease and its course. He had a case of abdominal grippe under his observation which form was not then epidemic. It begins with short prodromal symptoms, weakness and general malaise, violent headache, pain along the spinal column, in the nape of the neck, small of the back and very severe muscular pains in the lower extremities. Nausea and bilious vomiting are also present. There are severe chills during the day, appearing several times and followed by a burning fever. This continues for four to six days, the pains not decreasing in intensity. Then the bowels become constipated, a dry and very fatiguing cough sets in. Besides these there are important local symptoms: the abdomen very tense, distended and not painful to pressure; there is no gurgling on pressure in the right iliac fossa, but a little in the transverse colon; this was the rule in all the cases of the last epidemic. The spleen is slightly enlarged, the liver normal. A few rose-colored spots are to be seen on the abdomen to the number of four or five. They have all the characteristics of the lenticular rose-colored spots of typhoid fever. The heart beat is rapid and strong, there being neither souffle nor diastolic murmur. In the lung a few disseminated râles are found. No albumin in the urine at the beginning. The tongue is red at the point and white in the rest of its extent, yet dry like the lips. The muscular pains, especially in the buttocks and calves of the legs, persist with great obstinacy. There is also great cutaneous hyperæsthesia, indeed, pressure upon the abdomen is not painful, but the slightest pinch of the skin in this region causes actual suffering. The temperature is elevated with morning remissions. The beginning is sudden, after a short prodromal stage while in typhoid fever the symptoms gradually increase in severity. The patient is constipated usually, while in typhoid fever this is the exception rather than the rule. The cutaneous sensitiveness and persistence of muscular pains are characteristic of the grippe, in the typhoid form, although the rose-colored spots and the enlargement of the spleen are present. The temperature generally falls suddenly on the sixth or seventh day of the disease, when the other symptoms also are relieved. This form of the grippe is very rare,

and is only observed in isolated cases, especially at the beginning of great epidemics. The epidemic of 1890-91 presented types of the thoracic and nervous forms nearly exclusively, while that of 1891-92 produced a large number of cases of the abdominal type. This was especially true at the beginning of the epidemic, when the lecturer diagnosticated the cases all as typhoid fever until a few days had passed when he corrected his diagnosis. It is possible that this type was due to a mixed infection with the bacillus of typhoid fever as in the epidemic of 1833, the patients presented a choleric form type and this epidemic succeeded the epidemic of cholera in 1832. The sudden brusque commencement of the disease may be associated with epistaxis, vertigo and vomiting. There is constipation, as a rule, and the tongue is covered with a whitish coat of a pseudo-membranous appearance. In three or four days the condition of the patient aggravates, there is insomnia, delirium, deafness and the patient takes on a typhoid appearance. Sometimes, as in the ataxo-ady-namic form, there is a demi-coma, with hallucinations, carphologia and subsultus tendinum. This nervous excitement may last for seven days, and during its development the abdominal symptoms appear. The constipation may persist, though it is liable to be replaced by diarrhoea on the second or third day. The stools are then numerous, but little colored and not *fœtid*. The abdomen tense and sensitive to pressure, the abdominal muscles and skin sensitive and hyperæsthetic. There is gurgling, but like the pain it is over the entire extent of the abdomen. The rose-colored spots are not rare, though they appear to have escaped the attention of observers. The spleen is enlarged and painful, and the liver slightly congested. The urine is albuminous, at the height of the disease, for four to eight days. The disease is often accompanied by angina, laryngitis or bronchitis; this latter is associated with an important stethoscopic sign, an obscurity in the respiratory souffle. This latter may persist a long time after cessation of the disease. The temperature curve of this form of the grippe does not present any peculiarities, it is that of the other forms of the disease. There is generally a recurrence of the fever two days after deservescence of the disease, the curve resembling thus a letter V. Convalescence is generally tedious, the lassitude persisting for a long time. The asthenia is particularly marked after this form. The differential diagnosis is very difficult, for each symptom must be studied by exclusion.—*La Semaine Medicale*, No. 51, 1892.

MENTAL DISEASES FOLLOWING THE GRIPPE.—Dr. Julius Althaus finds that the mental diseases following the grippe are the same as those coming on after any infectious diseases, for example: rheumatism, pneumonia, erysipelas, typhoid fever, cholera, acute exanthema, etc. He concludes his work as follows:

1. Influenza is more often followed by mental disease than any other infectious affection. Typhoid fever only approaches it in frequency.

2. The male sex is most often attacked and the age most susceptible seems to be between the twentieth and the fiftieth year.

3. A predisposition exists in 72 per cent. of the cases. Alcoholism was present in 11 per cent. of the cases.

4. The toxine of the disease has a greater rôle in the production of the mental complications than the fever itself, for this latter is so low that it seems impossible that it could have such a disturbing influence.

5. With regard to the duration of the disease, 12 per cent. were cured in a week, 32 per cent. in a month while 50 per cent. lasted over a month.

6. As to the proportion of cures and deaths, 7.6 per cent. of the cases terminated in death, 56.6 per cent. in recovery and 35.8 per cent. remained stationary.

7. A careful study of the published observations show that mental diseases are especially liable to become manifest after light attacks (55.2 per cent.) while only 27.6 per cent. were found to follow severe attacks and 17.2 per cent. after moderately severe attacks.

8. Inanition delirium appears immediately after the attack while melancholia is observed several weeks after and general paralysis six months subsequently.

9. The psychoses following influenza have a peculiar character but they do not differ greatly from those coming on after other infectious diseases.

10. Influenza may have a varying effect upon the mental state of patients already insane. Certain patients are aggravated and others improved. These modifications are due, no doubt, to the changes in the cerebral circulation.

11. The treatment is the same as that of mental diseases from other causes.—*Le Bulletin Medicale*, No. 66, 1892.

GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D.

POTT'S FRACTURE AT THE ANKLE.—Stimson (New York), in an instructive article, calls attention to the frequency of this injury, the common mistakes in its treatment, and the resulting disability met with in consequence.

The lesions are, typically:

1. A fracture of the fibula from one to three inches above the tip of the malleolus.
2. A rupture of the internal lateral ligament, or a fracture of the internal malleolus.
3. A diastasis of the lower tibio-fibular articulation, with rupture of its ligaments, or, possibly, with avulsion of the adjoining portion of the tibia.

The fracture of the fibula is, clinically, the most easily recognized, and throws the other two into the background, to the detriment of the patient. It is usually oblique and well above the malleolus, which distinguishes it from the lesion produced by *inversion* of the foot, i.e., fracture near the base of the malleolus.

Next to this in importance is a rupture of the internal lateral ligament, or a fracture of the internal malleolus: this may be a breaking off of the anterior, inferior portion of the malleolus, or a transverse fracture at its base.

The third lesion is the rupture of the ligaments of the lower tibio-fibular articulation, or, rarely, an avulsion of a superficial plate of the tibia to which the anterior ligament is attached. The mortise in which the astragalus is held is thus loosened and the bone is displaced, immediately or after the addition of the weight of the body, outward. The astragalus is also displaced backward, partially or completely, by the action of gravity or the sural triceps. This is the essential lesion of the injury, and, if not corrected, will produce marked disability, the outward displacement causing excessive strain on the internal ligaments, and the backward limiting or abolishing flexion. Contrary to the generally accepted idea the upper end of the lower fragment (fibula) is not displaced inward, which is anatomically impossible, but the external malleolus is pushed outward by the displaced astragalus which has also slipped backward along the lower end of the tibia.

As to the mode of production clinical observation and experiments on the cadaver show that it is due to outward rotation of the foot or eversion of the ankle. The anterior tibio-fibular ligament yields first, the joint gaping considerably; then the anterior fibres of the internal lateral ligament give way, and, almost coincidentally, the fibula breaks obliquely, by a twisting of its lower end, the upper fragment terminating close to the ankle-joint.

The diagnosis is made:

1. By inspection alone, at times, the deformity being quite characteristic. It should be borne in mind that the "text-book" symptom, eversion of the sole, is rarely present, and indicates excessive outward displacement or very tense peroneal muscles.

2. By the recognition of three points of localized tenderness on pressure: one over the front of the lower tibio-fibular articulation; another at the seat of fracture of the fibula, two or three inches above the apex of the external malleolus; the third at or just below and in front of the internal malleolus.

3. By making out the outward and backward displacement and lateral mobility.

(a.) The foot is grasped with one hand, so that the posterior portion of the sole rests in the palm, with the thumb close below the external malleolus and the index finger below the internal malleolus, and moved bodily inward and outward, while the other hand grasps the leg well above the ankle and steadies it. The outward displacement is reduced by inversion, but recurs, and hence must be held in place.

(b.) The foot is grasped with both hands, so that the fingers rest on the back of the heel and the thumbs on the front of the lower end of the tibia, and then, the sole being vertical, it is lifted with the fingers while the leg is held back by the thumbs, and then allowed to drop back again. The displacement is produced by gravity and by contraction of the muscles of the calf; it is more readily seen when the foot is extended, producing a distinct prominence in the dorsal outline.

Unless the surgeon's attention is specifically directed to the detection of these displacements they will pass unrecognized. Anæsthesia, pushed to complete muscular relaxation, is usually necessary to fully demonstrate the displacement and to accomplish complete reduction.

The indications for treatment are reduction and retention.

Reduction is accomplished, with the aid of an anæsthetic if necessary, by bringing the external malleolus back to its place (forward and inward) alongside of the tibia, to re-establish the mortise containing the astragalus. The foot is pressed forward and inward as far as it will go, its front adducted and its sole inverted. This cannot be carried too far.

Retention is accomplished by lateral and posterior moulded splints of plaster of Paris (twelve to fifteen thicknesses of the ordinary four-inch plaster roller). The posterior splint extends from the toes, along the sole, around the heel, and up the calf nearly to the knee; the lateral one begins just in front of the external malleolus, passes over the dorsum of the foot to the inner side, under the sole, and upward along the outer side of the leg to the same height. They are moulded and bound to the leg while wet with an ordinary roller bandage, which is removed when the plaster has set, and replaced by a few circular turns just above the ankle and at the upper end of the splints; they should overlap to prevent shifting; new ones are applied in a few days.—*New York Medical Journal*.

FRACTURE OF THE UPPER END OF THE ULNA WITH DISLOCATION OF THE HEAD OF THE RADIUS.—M'Leod (Calcutta), from clinical experience, experiments on the cadaver, and a study of Hamilton's and Agnew's statistics concludes that:

1. This combined injury is common, and it is due to direct violence generally, the point of application and degree of the force determining whether fracture alone, or fracture with dislocation result.

2. The deformity is characteristic; the upper fragment of the ulna is pushed or pulled forwards and outwards, causing angularity of the shaft and some bulging at its upper end; the head of the radius lies in front of the external condyle of the humerus causing some fulness there.

3. The displacement of the upper fragment of the ulna is due to the violence and to traction by the oblique and orbicular ligaments, and the supinator brevis muscle.

4. When the displacement of the radius is not detected and remedied, the ulna unites in its distorted position and the limb loses efficiency in motion and power.

Hence, the following practical precepts are laid down:

1. In every fracture of the upper end of the ulna, dislocation of the head of the radius should be carefully looked for.

2. If such dislocation is found, it should be at once reduced, the displacement of the upper fragment of the ulna being corrected at the same time.

3. As it is difficult to retain the head of the radius in position after reduction the parts should be frequently examined to be sure that the head is in place.

In one of the cases referred to, compound fracture of the ulna (upper end) with forward dislocation of the head of the radius in a strong adult, attempts at reduction by extension, counter extension, and manipulation were unsuccessful. On strongly flexing the forearm the head of the bone slipped into place and retained there on extending the joint. The fracture was reduced at the same time.—*Lancet*.

(We recall a case in which a fracture of the ulna at the junction of the middle and lower thirds was associated with forward dislocation of the radius. The fracture was compound and the wound had healed after considerable loss of substance in the ulna. The arm was extended and useless. Reduction being impossible the head of the radius and about an inch of the shaft were resected when by flexing the forearm the bone was readily pushed into place. The result was very satisfactory.—Eds.)

Williamson (Manchester) reports a case of this injury in which it was found impossible to reduce the ulnar displacement. More careful examination showed an anterior luxation of the radius. Reduction of the latter partly rectified the displacement of the fracture which was then easily completed.—*Lancet*.

RADICAL CURE OF FEMORAL HERNIA.—Watson Cheyne (London) describes a method which he has successfully practised for the radical cure of femoral hernia. The attempt has hitherto been made to approximate Poupart's ligament and the fascia over the pectineus muscle. As the ligament is a tense band, either the stitches cut through it, or through the fascia. In fact, operations for the cure of

femoral hernia are not nearly so successful as those for the inguinal variety. To prevent the tearing out of the stitches, and to fill up the femoral canal, the writer operates as follows:

The hernia is reduced; the neck of the sac ligatured and stitched to the abdominal wall on the inside (Barker). A flap is then cut out of the pectineus, including the whole thickness of the muscle, of sufficient size to fill up the crural canal without any tension. The incision begins at the inner edge of the crural canal, runs for a short distance parallel to Poupart's ligament, curves downward, then outward, and finally upward to the outer side of the canal. Two stitches are passed deeply through the lower portion of the flap and tied, the ends being left long, when the muscle is peeled upward from the bone and fastened in the femoral canal by passing the two pairs of ends through the abdominal wall, from within outward, at and above Poupart's ligament, and tying them. The sutures are Chinese silk. The canal is completely filled up with a thick mass of muscle, which unites with the surrounding tissues; if the muscular elements atrophy, a dense fibrous tissue will be left behind. Two cases were successfully operated in this manner, there being at the end of five months no cough impulse, no truss being worn, and the region of the femoral canal remaining a hard mass.—*London Lancet*.

Salzer (Utrecht) suggests a somewhat similar procedure which he tried successfully in a case of large relapsing femoral hernia.

After the sac was tied off, a flap of fascia was raised from the pectineus muscle; it was semi-circular in shape, beginning under the femoral vessels and ending at Gimbernat's ligament. The free edge was stitched, without tension, by silk sutures to the middle third of Poupart's ligament, forming a firm, fibrous septum crurale. Primary healing followed, and the patient wore no truss. The thickness of this fascia varies in different individuals, being stronger in elderly adults, and particularly in those who have old herniæ and have worn trusses.—*Centralblatt für Chirurgie*.

RADICAL CURE OF HERNIA.—Kocher (Bern) adds another to the numerous procedures for the cure of hernia, which may be classed more particularly among the methods of treating the sac. Its aim is to render tense the peritonæum in the region of the inguinal opening, the stretching being made, however, in a direction opposite to that of the inguinal canal and the course of the hernia.

The sac is exposed, isolated, and drawn down until its neck is made out. The index finger is passed into the inguinal canal, and on it an opening is made in the aponeurosis of the external oblique opposite the internal ring. The sac is drawn through this opening by artery forceps which have followed the finger out of the inguinal canal. It is made tense by traction, twisted (Ball) strongly, and firmly fastened to the outside of the aponeurosis of the external oblique, along the line of the inguinal canal, and over the external ring. This acts as a pad, and also, by pressure, tends to approximate the walls of the canal.

In femoral hernia the twisted sac is drawn through a small opening above Poupart's ligament, brought down and included in the sutures passed through the pectineal fascia and Poupart's ligament to close the femoral ring.—*Correspondenz-blatt für Schweizer Aerzte*.

PNEUMOTOMY FOR TUBERCULAR ABSCESS AND GANGRENE.—White (New York) reported to the New York State Medical Association a case in which this operation was done twice in the same patient. A girl, 13 years old, had had an acute broncho-pleuro-pneumonia, engrafted on an old unresolved pneumonia, which degenerated into a fibrosis involving the right lower and part of the middle lobes. A large area of the lung became gangrenous, and an abscess had opened into a bronchus. An incision was made in the sixth intercostal space, an inch anterior to the axilla. Fluctuation being made out the lung was incised and two ounces of fetid pus evacuated. Relief was immediate and continued until a month after the tube was removed when reaccumulation took place and produced urgent symptoms. It was in the posterior portion of the lower lobe. The chest was again opened behind the axillary line and a similar condition found. Besides the pus some gangrenous pieces of lung were removed. Repeated irrigation, drainage and antiseptic treatment resulted in complete healing, the tube being worn eight months. At the end of two years the patient was in good health. Irrigation, which must be practiced with care, is less dangerous in gangrenous cavities than in those discharging laudable pus. Such cases are never too far advanced for operation, which offers the only hope. Adhesions of the pleura are not essential, and waiting for their formation is often disastrous.

GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D. AND J. NICHOLAS MITCHELL, M.D.

HYSTERECTOMY.—The author reviews the different methods of performing hysterectomy, both partial and complete. In supra-vaginal or partial hysterectomy the cervix is not removed, but constitutes the pedicle; and it is in the treatment of this pedicle that the dangers of the operation is evidenced. In the extra-peritoneal method, the difficulty of drawing it outside sufficiently to fix it at a suitable height; the irritation to the peritonæum, the bladder, etc.; pain; and liability to abscesses and septicæmia, etc., constitute the objections, while the greater danger from hæmorrhage and septicæmia in the intra-peritoneal method make many fear it also. In confirmation of the dangers resulting from leaving the stump of the cervix he quotes Boileau as follows: "having made inoculations of fragments of the necks removed in complete hysterectomies by Martin, pathogenetic germs were found seven times out of ten, in the segment of the neck, which would have served as a pedicle in a supra-vaginal amputation." He gives the indications for abdominal hysterectomy after Pozzi: "Rapid increase of the tumor; severe hæmorrhages, yielding to no palliatives; ascites, produced by the irritation of a very movable tumor; compression of the organs contained in the pelvis or abdomen, especially the bladder and the ureters; considerable volume in the tumor, especially, cystic, œdematous, or suppurative degenerations; symptomatic prolapsus of the uterus, and pregnancy when the tumor would evidently be a cause of dystocia." The counter-indications for the operation he says, are excessive debility; advanced age; considerable vascular adhesions extending to the abdominal walls, and finally, a complication of cancer with the fibro-myoma; this last cause, he states as positive, as an extirpation of a cancerous uterus through the abdomen is a very grave operation; the mortality frightful (67, 2 p. 100), and the benefit doubtful, since relapse is almost certain.

By the removal of the cervix as well as the body of the uterus, all the risks and dangers of the supra-vaginal operations are avoided, and this may be accomplished in two ways, either by the abdomino-vaginal hysterectomy which consists in the removal of the myoma through the abdomen, and of the cervix through the vagina, which our author designates as Pean's operation; and hysterectomy entirely abdominal, which consists in the removal of both the myomatous tumor and the cervix through the abdomen, this latter method being employed by Martin and Bardenhauer, in Germany, but especially demonstrated by M. Guernonprez, in France, and who has made it the subject of two communications to the Academy of Medicine (meetings of September 15 and 22, 1891), and which have since been completed by some "experimental researches," presented to the Anatomico-Clinical Society by MM. Guernonprez and F. Duval (March 8, 1892), and by the thesis of M. F. Duval (Paris, 1892).

He quotes Pean for the indications and technique of the operation of abdomino-vaginal hysterectomy, as follows: "after opening the abdomen, draw the tumor upwards by means of a long curved trocar, and place an elastic ligature around it as near as possible to the cervix, and fasten the ligature by a pair of forceps, and then resect all the tumor above it. Nothing remaining then but the cervix and inferior part of the body of the uterus, care must be taken to separate the bladder and rectum and to compress or tie all the little vessels which belong to them.

"A metallic ligation is then placed above or below the elastic ligature, as the case may be and is tightened firmly, and twisted by the aid of an assistant. The stump is then resected as near as possible to the metallic ligature, care being taken to hollow out the mucous, in order to diminish the size as much as possible without abandoning the ligature, then the stump is reduced and the abdominal wound closed by sutures.

"There remains only then to remove the neck of the uterus, the stump and the metallic ligature. This extirpation is easily accomplished by the vaginal passage by following the rules which we have a long time ago laid down for the ablation of small uterine tumors, that is by compressing the broad ligaments and dividing it up.

"By reason of the results that we have obtained by this new method of ablation of the uterus totally, for some years we have come to lay down the following conclusions:

"1. Every time that the removal of a large fibrous, fibro-cystic, or interstitial tumor of the uterus is indicated, it is best to have recourse to the method of total ablation through the abdomen and through the vagina combined.

"2. This method permits of a more rapid removal of the diseased uterus and its annexes than the intra- or extra-peritoneal methods."

En résumé, Pean's operation comprises two: the first is simply a supra-vaginal hysterectomy, the second a vaginal hysterectomy. The operation of M. Guernonprez does away with the vaginal hysterectomy; the cervix is removed not by the vagina but by the abdomen, and in this consists the superiority of the method.

The operation of complete abdominal hysterectomy is described as follows: After incising the linea alba and lifting up the mass of intestines the surgeon grasps the fundus of the uterus and forcibly lifts it into view. Only one-half of the uterus can be brought into view, and no effort can lift up the rest. In front of it the soft and flabby walls of the bladder are easily recognized. The peritonæum appears differently on each organ; on the bladder it is corrugated, puckered and very movable on the subjacent tissue, owing to the loose cellular tissue which separates them, and this is particularly noticeable when the bladder has been recently evacuated; on the uterus it is smooth and intimately adherent to the subjacent tissue. Behind, nothing is to be seen. The extreme tension of the broad ligaments are to be particularly noted, and especially in the inferior and middle parts, as this explains the difficulty in raising completely the uterus out of the pelvis. The broad ligaments must then be divided along the border of the uterus and as far as the bladder which causes the Fallopian tubes and ovaries to fall outwards and backwards, the circular shape of the bladder disappears, and it extends itself forwards and backwards; the corrugations of the peritonæum on its border are completely effaced and most important of all it then becomes possible to lift the uterus completely out of the pelvis, which allows of its separation completely and methodically from the bladder. To accomplish this a transverse section of the peritonæum is made at the exact limit of the vesico-uterine fold, which is easily recognized by touch, when the separation is completed, partly by the fingers and partly by a bistoury. Little by little the bladder is pressed back below and in front. (In the living the tonicity of the vesical muscles favors the separation notably.) The transverse folds of the peritonæum which are reflected over the bladder then appear more clearly. When the ostium becomes accessible the separation is completed, but to make one's self certain vaginal touch combined with palpation of the wound is necessary. This separation being accomplished, a narrow opening is made in the median line directly in front of the os in order to make an opening into the vagina; through this opening a cannulated sound is passed in front and behind in the median line across the posterior vaginal wall in order to enter the cul-de-sac of Douglas. Everything can be executed easily and rapidly on the cadaver without injuring the ureters and without failing in any of the general rules of surgery.

The advantages claimed by the author for complete hysterectomies over the supra-vaginal are that the cervix being so often the nidus of infection its removal lessens the dangers of the operation, as when the cervix no longer exists, it is very easy to disinfect the vagina thoroughly, as, far from being the source of infection, the vagina gives free exit to the discharges from the wound, and combines all the qualities that one would desire for perfect drainage, since it is large, dependent and aseptic; hæmorrhage can be easily arrested also since the arteries can be seized by forceps and tied with certainty.

The disadvantages are the separation of the bladder and cervix, while always possible, when done with prudence and care is very tedious; the time occupied in operating is lengthened; a greater amount of an anæsthetic is necessary; the peritonæum is exposed for a longer time to the air; there are a greater number of chances of committing some errors in antiseptic, and finally, and above all things, there is an aggravation of shock from the operation. He says, however, that with increased skill and knowledge on the part of surgeons these objections lose much of their importance, and quotes Pean as saying "that complete hysterectomy is an operation notably shorter than the supra-vaginal operation."

Our author states that since the month of December, 1891, M. Le Bec, surgeon to Saint Joseph's Hospital, has operated seven times after Pean's method with four successes and three deaths, of which one died from disease of the heart, one of hæmorrhage and one from peritonitis. More recently Professor Lannelongue, of Bordeaux, has "congratulated himself on having performed Guernonprez's operation." In comparing the two operations of complete hysterectomies, that which he

calls Pean's and that of Guernonprez, he claims the latter as superior, since the separation of the bladder, the section of the broad ligaments, the tying of the vessels, in fact the entire operation can be performed in full view of all the parts.

He relates three very interesting operations performed by Guernonprez, with two deaths, but explains that these were caused not by the operation itself, since one was complicated with cancer and one was poisoned by mercurial injections.—E. Camelot, *Nouvelles Archives d'Obstetrique et de Gynæcologie*, 1892, pp. 377, etc.

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

ANTIPYRIN IN PANNUS.—Vignes following the lead of Alder and Mergé, has used antipyrin as a local application in the treatment of pannus. He reports one case in detail, and mentions that encouraged by the results therein obtained, he has employed the remedy in others. Cocaine is first used, and when the conjunctiva is anæsthetic a thin layer of antipyrin is applied to the surface of the cornea. In spite of the cocaine anæsthesia, a certain amount of pain and lachrymation is excited. These symptoms subside in a few minutes, and then gentle massage over the closed eyelids should be employed. This treatment is followed by sharp inflammation, reaction in the conjunctiva, and the quantity of drug used and the frequency of its application must be regulated by the severity of the reaction and the gravity of the case. If it seems advisable to excite a purulent conjunctivitis, the powder must be applied every day. As soon as this condition is produced, however, the treatment is changed for warm anodyne lotions. Vignes thinks this method most suitable for cases of strumous pannus, complete or incomplete. In trachoma cases he would only employ it if, as sometimes occurs, the pannus persists after the conjunctival granulations have disappeared. He considers this treatment much safer than inoculation with gonorrhœal pus, and more easily controlled and safer than applications of jequirity.—*British Medical Journal*, October 15, 1892.

SUDDEN DEATH FROM IMPACTION OF MEAT IN THE LARYNX.—Dr. H. M. Biggs presented to the New York Pathological Society, a larynx removed from a man who had died very suddenly, and his object in presenting it was to give greater prominence to a not uncommon cause of sudden death, namely, the lodgment of foreign bodies in the larynx. This man, while sitting in the restaurant eating soup, was observed to cough suddenly and to have a slight convulsion, and in a moment he was dead. After hearing this history, and before making the post-mortem examination, the speaker had expressed the opinion, based on a dozen or more similar cases, that death in this case was due to suffocation from the presence of a foreign body in the larynx. An important point in the history is the occurrence of a slight convulsion. At the autopsy a very large piece of meat was found so situated as to absolutely occlude the larynx. Death certainly does not take place in these cases from suffocation simply, but whether or not it was due to a reflex inhibition of the heart's action he could not say. He had seen quite a variety of foreign bodies in the air-passages; thus, in one case a collar button formed a complete ball-valve; in another a screw was found; in a third a toy balloon had been drawn into the trachea, and was inflated with each inspiration; in still another, a bronchial gland had caused suffocation by discharging its contents into the trachea.—*Medical Record*, November 19, 1892.

HYSTERICAL APHONIA—The treatment of hysterical aphonia practiced by James A. Bach, M.D., of Milwaukee, Wis., consists of teaching the patient inductively to regain control of the larynx, to innervate properly the muscles of the vocal cords and produce voice.

Where the inability to whisper is apparent it takes some preliminary steps before attempting to produce vocalization. This can be overcome by directing the patient to inhale deeply and blow out again with a puckered mouth, and after this to blow with the tongue pressed against the upper teeth, producing the sound of S. A few minutes' practice in this will enable one to have the patient blow any of the letters, holding the tongue and upper part of the throat in proper position.

Should the patient try to evade the production of whispered sound in this manner

by holding his breath, a sudden pressure upon the chest of the patient by the physician, sufficiently hard to expel the air, will at once get him over this fault, and he will in a few moments be able to whisper. The moral effect produced is one of assistance. Now go on with vocalization.

The greatest difficulty with the hysterical patient is the production of the first tone, as such patients are generally unable, through their own efforts, to produce any sound whatsoever. This initial difficulty, however, can always be overcome in a few moments by the assistance of reflex action. For this purpose a mild irritant, whether mechanical or chemical, may be applied to the larynx so as to excite cough. If the interlaryngeal anæsthesia is great, inject some non-irritating fluid, as warm water, into the larynx, which will produce cough readily. The patient will then be able to reproduce this cough independent of the irritant. While coughing it is well to have the patient close his mouth and produce a rasping movement in the throat as though trying to free it of mucus, while the physician supports the larynx with his hand, exerting some pressure latterly.

The patient continuing to cough, let him pronounce, as distinctly as possible, the vowel "a" at each effort, and then to substitute the vowel "e," and so on until all the vowels have been coughed. He should then eliminate the cough element, pronouncing the pure vowel sound, which may then be combined with consonants, as with "d"—"ad," "ed," "id," "od," "ud," and other combinations. The patient is thus led to speak words without resisting, wilfully or otherwise. The time occupied in this procedure need not be more than half an hour. At the next treatment it may be necessary to again go through the coughing process.—*New York Medical Journal*, Oct. 22, 1892.

THE SENSE OF SMELL.—In a recent number of the *American Journal of Psychology* Professor Jashow communicates the results of observations made on a student twenty-one years of age, who suffered from complete anosmia. The patient's mother had had no abnormality of smell until she was thirteen or fourteen, when she had completely lost the sense. In the patient on whom the observations were made the defect was evidently congenital. Taste as well as common and thermal sensibility were undisturbed, and the patient therefore offered a good opportunity for testing the sensations in the mouth and nose, and it might be inferred that differences which he could perceive in savory substances were perceived not by smell but by some other sense. The interesting investigation showed that the greater number of taste perceptions, as they are commonly understood, are really to be referred to smell. No distinction could be made between tea, coffee and hot water, so that he took the last named, with sugar and milk, as his ordinary breakfast beverage. He confused bitter almond water and water three times in five trials, while he correctly discriminated ether and water, the former, he said, producing in his throat the sensation of peppermint. With ammonia and ether he was right six times in eight trials; and Professor Jashow ascribes the two errors to fatigue. The various fruit syrups he could not distinguish, merely recognizing them as sweet. Mustard produced a sharp sensation on the tongue, but was not recognized any more than pepper, while cloves and cinnamon were distinguished. Differences of one degree of temperature were easily recognized.

THE PRIME ÆTIOLOGICAL FACTOR OF GLAUCOMA IS CONSTITUTIONAL.—Dr. S. O. Richey, of Washington, D. C., calls attention to Mr. Priestly Smith's theory of glaucoma, to the observation and experiences of others opposing it, and himself objects to Mr. Smith's as of too local and limited character. Reasoning from Schnabel's conclusion, increased tension is caused by too rapid infiltration, to which a *vis a tergo* is essential, as is found in the uric acid diathesis.

"Many manifestations of rheumatic gout are associated with chronic glaucoma, viz., enlarged or distorted joints, a peculiar senile pallor, or muddiness of the skin, periods of mental depression, and other symptoms attributable only to changes in the nervous system. The neurotic character of chronic glaucoma is argued, its origin thought to be the absorption of toxic substances from the intestinal tract, the results of indigestion, for which reason, it is claimed, operation in chronic glaucoma is unreliable.

In case of chronic glaucoma, the writer advises control of the quantity and quality of food to the exactness of physical needs, the prompt excretion of improper intestinal products, the use of uric acid solvents (lithia and piperazin), strychnia and galvanism as the wise course.

MONTHLY RETROSPECT OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D., AND FRANK H. PRITCHARD, M.D.

SYMPTOMATOLOGY OF CARBO VEG.—The Medical Investigation Club, of Baltimore, presents the following symptomatology of carbo veg. as the result of its analysis of the provings of this drug:

Generalities.—A general relaxed feeling⁶; expressed as weakness²; languor²; fatigue².

Mind.—Mental depression².

Head.—Vertigo³. Headache¹⁰; the pain is acute⁷; dull⁵; frontal³; in side of head⁹; both sides³; temporal region⁶; of the left side³; parietal region³; occipital region³; throbbing sensation in temporal region²; scalp sensitive².

Eyes.—Eyes weak with inclination to keep them closed²; pain in the right eye².

Nose.—Discharge of mucus from the nose²; sneezing².

Mouth and Tongue.—Irritable condition of mucous membrane of lips with tendency to ulceration³; tongue furred²; disagreeable taste in the mouth³.

Throat.—Throat feels sore⁶; expectoration of mucus from the throat³.

Stomach.—Appetite diminished³; thirst⁷; eructations⁴; which are sour and bitter²; nausea³; a faint feeling in the stomach²; uneasy sensation in the stomach⁴; as though containing some foreign substance²; the stomach is painful².

Abdomen.—Sensation of fulness in the abdomen²; flatulence³; the abdomen is painful, tender²; sore².

Stool.—Constipation⁵ (slight in two provers); diarrhoea³ (none of whom had constipation).

Urinary Organs.—Urine increased in quantity⁴; of a light color²; passed frequently³; urgent desire to micturate³; urine scanty and dark².

Respiratory Organs.—Irritability of the mucous membrane of the respiratory organs²; cough³; with expectoration of mucus².

Neck and Back.—The cervical muscles are painful²; sore to the touch³; pain in the lumbar region³; sharp in character²; there are uneasy sensations in the sacral region².

Limbs.—Legs and arms are inclined to "go to sleep"²; hands and feet cold³; feet cold⁴; damp³.

Sleep.—Restless at night²; wakeful at night³; sleepy during the afternoon⁴.

Chill and Fever.—Chilly sensation³; sensation of increased heat of the body³.

Aggravation.—Headache is worse on motion².

Therapeutic Applications.—A general debility is characteristic of the remedy. In this the circulation is more or less disturbed and rendered less active than normal. With this relaxation there may be mental depression, the digestion may be impaired, and other concomitants such as constipation, headache, etc., should be expected. Frequent micturition of light colored urine will further suggest the drug.

Respiratory Mucous Membrane.—In acute catarrh of the pharynx and larynx and trachea and even the bronchi, carbo veg. is of service when the throat feels sore and irritable, causing cough with expectoration of mucus. This sore feeling extends to the larynx or even to the trachea. In acute cold with chilliness followed by pain and soreness of the posterior cervical muscles and the back, with the foregoing symptoms, vegetable charcoal should be a good remedy, and if the urine be dark and scanty, it will be even better indicated.

Gastric Derangements.—According to the pathogenesis, *carbo veg.* is indicated in flatulent indigestion, wherein the patient becomes nauseated and has sour bitter eructations. The bowels become irregular, being usually constipated, or in some cases inclined to diarrhoea. The gastric irritation also extends to the fauces, the tongue becomes coated, and there is a solution of continuity of the mucous membrane of the buccal cavity. The appetite is poor.

In the *general abdomen*, there is a sense of abnormal fullness, which is proved to be real by the gaseous eructations. The abdomen is also painful and sensitive to touch.

From interference in the *digestive functions*, the circulation may become disturbed, a general uncomfortable feeling of debility experienced, and also the concomitant, restless sleep.

Following the general systemic derangement we may expect an interference in the excretory function of the kidneys, and as with the alimentary dejections, so we here find the flow of urine either too scant or too profuse.

The headache has no characteristic pain unless we consider the predominant acute pains as such, and either the frontal, sincipital, occipital, parietal or temporal regions may be affected; though the side of the head is most frequently painful. The drug should always be studied when there is persistent headache from gastric disorder.—*Southern Journal of Homœopathy*, November, 1892.

TREATMENT OF PAROXYSMAL COUGH.—The following is a recapitulation of the discussion in the French Homœopathic Society on the treatment of paroxysmal cough. Dr. Jousset, the elder, enumerated the following remedies as producing spasmodic cough, with vomiting or efforts at vomiting and a more or less marked tickling in the throat: *drosera*, *corallium*, *hyoscyamus*, *rumex crispus*, *pulsatilla*, *conium*, *cina* and *cuprum*.

Drosera produces a convulsive cough resembling that of whooping cough. There is vomiting of watery fluid or food, excited by a tickling in the larynx, pharynx and sometimes in the *velum palati*. This cough which is sometimes suffocating may be accompanied by pains in the thoracic walls, epistaxis or purulent or bloody expectoration. It is suitable in whooping cough, the second period of a cold and in the cough of phthisis. The third to the sixth are sufficient in pertussis and the second period of a cold while the mother tincture is required in phthisis, twenty to thirty drops.

Corallium has the same characteristic cough as *drosera*. The sixth to the thirtieth may be administered when *drosera* is without effect.

Hyoscyamus is indicated when the cough is aggravated at night, by lying down, obliging one to sit or sit up in bed and by expectoration of a very abundant and watery mucus. The first six dilutions are given.

Rumex crispus is especially serviceable in epidemic gripe. Its chief indications are a tracheo-laryngeal cough which is violent, incessant and principally nocturnal, caused by a tickling in the larynx, aggravated in the horizontal position, by pressure on the larynx, speaking, and especially by breathing cold air. Expectoration is difficult and scanty. The first few dilutions are used.

Pulsatilla is characterized by the horizontal position producing an aggravation and the open air an improvement. Urine is voided involuntarily with the cough, and the expectoration is loose. The concomitance of coryza, with a loss of smell is also another good indication for the remedy.

Conium is indicated in a pertussis-like cough, with aggravation at night and in the horizontal position. There is pain in the larynx and the tickling which provokes the cough may be in the throat or substernal. The third to the sixth may be employed or even the mother tincture.

Cuprum and *Cina* are indicated in convulsive coughs with vomiting of foods and tickling in the larynx, but less pronounced than in the preceding remedies. Their cough is accompanied by a convulsive involvement of the entire body. The cough of *cuprum* is suffocating, while the lips and face become blue; this is a capital indication. That of *cina* is often accompanied by sneezing and a swallowing movement. The sixth to the third dilutions are administered.

Dr. Simon, Jr., besides these remedies would call attention to the value of *veratrum* in these coughs. It presents a great analogy with *cuprum*. He saw it act very rapidly in a case of whooping cough, with cyanosis. He also recommended it in intestinal tuberculosis. *Aralia racemosa* is of service in paroxysmal coughs recurring after a short sleep.—*Revue Homœopathique Belge*, 1892.

ANTIMONIUM CRUDUM IN CHOREA.—Dr. M. Jousset records the case of a little girl of five years, who had been suffering from chorea for fifteen days. It was more marked on the right side. Several remedies had been given without any result, and a month after the beginning of the disease the jactitations were fully as strong though ceasing during sleep, which was quite satisfactory. The child was so awkward that it tumbled over the furniture and frequently fell. For several days the appetite had diminished and even a disgust for food had been noticed. Zincum, which was then being taken, was discontinued and antimonium crudum was administered in order to re-establish the appetite. Soon after this remedy was given, in the third trituration, the appetite reappeared and the choreic movements became less energetic and decreased in intensity. In four days the disease had so decreased in violence that the drug was interrupted, and as the movements appeared to gain in intensity it was again given for fifteen days, when the state of the patient was so favorable that it was sent into the country as convalescent. Although there are no choreic symptoms in the pathogenesis of this drug of any great prominence, it is worthy of trial in those cases where the appetite is diminished, with a disgust for food.—*L'Art Medical*, No. II., 1892.

EXPERIENCE WITH A FEW HOMŒOPATHIC REMEDIES—Dr. Zwingenburg, of Berlin, contributes the results of his experience with a few homœopathic remedies.

Thuja.—He has often made provings on himself with this drug, taking the dilutions and the mother tincture, for six months, at a time, on account of a pigmented nævus, but without success. No symptoms were remarked beyond that he became reduced in weight, during the period. He is certain of two indications, namely, in angioma simplex and in syphilitic ulcerations of the throat, from gummatous degeneration.

The angioma disappears within two to three months, by becoming paler and paler finally to completely become invisible. The second to the third decimal dilution, three to five drops per dose, and two or three doses per diem, in a teaspoonful of water. This is continued uninterruptedly during the entire treatment, and fourteen to twenty-one days thereafter. Externally nothing was applied. The doctor has obtained quite a local reputation, in the treatment of teleangiectases, in children. A teleangiectasis rarely heals spontaneously.

The second indication was communicated to him by an allopathic assistant in a German university, who had treated, and in vain, a patient for syphilitic ulceration of the throat from gummatous degeneration. The patient had gone to a homœopath who had cured him with thuja, 3, and in a few weeks.

Plumbum.—Lead will cure Bright's disease, at least in the incipient and middle stages, while there is a $\frac{1}{2}$, 1, or 2 per cent. of albumin, in the urine (Esbach). Whether when the percentum is higher the writer has not had opportunity to observe. (Gatchell claims that plumbum is of service only in the red granular, gouty, kidney.—EDS.). Diet and proper clothing are, of course, not to be neglected. The feet should be kept warm, and wet and cold avoided. No beer, asparagus, or diuretics must be taken. Small quantities of wine are allowed. Milk, in unlimited quantities, if well digested. The plumbum is administered in the acetate, four grains, of the second decimal trituration, three or four times a day. As common water is to be avoided in the prescribing of plumbum aceticum, either the powder is poured dry upon the tongue or it is given in pills, one grain of the acetate being made up into twenty pills, with a proper vehicle. The remedy must be given for months, uninterruptedly, for a cure requires, as a rule, from one and a half to three months. Whether one is giving the right dose can only be determined by frequent examination of the urine, for albumin and cylinders. It may be necessary to rise or fall, in the size of the dose. For this purpose Esbach's albuminometer is the most convenient apparatus. This will be a certain guide in the treatment of the disease as if too large doses are given, lead producing this affection in the normal human being will aggravate the state. Then decrease the size of the dose. On the contrary, the affection is too serious to begin and persist with small and too minute doses. As a general rule one-twentieth of a grain will suffice. Lead is homœopathic to Bright's disease, and not to cardiac albuminuria. The condition of the kidney, in lead poisoning, Bright's disease and gout are scarcely to be differentiated. During lead colic hyaline cylinders are to be found in the urine and homœopathic works cite dropsical effusions in the various parts of the body. If used in cardiac albuminuria it reduces the albuminuria but little, while the

heart becomes weaker and arrhythmia, and indeed, even threatening symptoms may set in. Plumbum is also of service in gout for the articular manifestations.

Argentum Nitricum—This he regards as the most efficacious remedy in ulcerations of the gastric mucous membrane. It is not to be given in solution but in pill form, one grain of the crude drug to twenty pills, prepared in a dark place. Of these the patient is to take one three times a day, on an empty stomach. Lead and the nitrate of silver are to be given in pill form as they are decomposed in the presence of soaps, cheesy, albuminous substances, plant pigments, tannic acid and its congeners and common water. The silver is turned into the insoluble chloride. Care is to be taken that the stomach is not overfilled, thus preventing the ulcers from healing. Too hot or cold foods destroy the granulations. He recommends foods to be taken at regular times, with short intervals, no distension of the stomach. In this manner the stomach is not overfilled, and the peristalsis and secretion are maintained at an equal state. In deep ulcerations during the first five days, nothing but milk and barley soup is to be allowed. In punctate erosions of the gastric mucous membrane, which are indicated by a sensation in the stomach after meals, as if there were a sore spot in the stomach, the best remedy is the subnitrate of bismuth, 2x, a small powder, three times a day. In the female sex, he prefers the valerianate of bismuth, in the same form and dose.

Arsenicum—He uses the pure acidum arsenicosum, in preference to the other arsenical preparations. The arseniate of quinine he sometimes employs in weak states. Arsenicum is the chief remedy in peritonitis. In peritonitis he administers a twentieth of a grain of the second trituration, every two hours. In the intervals one may give five drops of the second dilution of bryonia. In women, in confinement, especially when the abdomen is covered with a miliary eruption, the arsenic may be given until the thirst symptoms set in, i.e., when he drinks often yet but little at a time. Then it must be discontinued. Besides this, warm poultices, absolute quiet in the dorsal position, and only fluid food is to be advised. Bryonia has a specific action on the serous membranes and directs the arsenic to these parts. Great care is to be exercised that the exudate becomes encapsulated, and every motion, pressure, etc., be avoided that it be not disturbed. During the night oil may be rubbed in and this covered with cotton. The same results may be obtained in peri-typhilitis. If begun in the beginning this treatment will relieve it in three to five days. In chronic diseases when Cheyne-Stokes respiration sets in, arsenic will give the patient great relief.—*Zeitschrift des Berliner Vereines Homœopathischer Aerzte*, Bd., xi., Hft. 2.

SAMBUCUS IN ASTHMA.—Dr. Fred. B. Percy reports the following cases of asthma, in which *sambucus* did efficient service :

CASE I.—Mrs. C., æt. 48, neurotic temperament, brunette, physical health good, but one year ago had severe attack of zoster, in which the neuralgia was most intense and persistent. Present illness attributed to long ride when overheated. Suffering from severe paroxysmal hollow cough, dyspnoea and slight elevation of temperature. Physical examination showed no dulness, but marked mucous and sibilant râles over both lungs. *Sambucus* θ , gtt. x in \mathfrak{Z} ij. aq., two teaspoonfuls every half hour. Improvement began promptly, and the patient was well in three days.

CASE II.—Boy, æt. 14 months. Fat, robust baby, fed on artificial food. Parents in good health. Mother inherits a tendency to asthma from her father, and during pregnancy and for some months after confinement she suffered intolerably from asthma. The baby when a few months old had convulsions, which were attributed to dilatation of the stomach, and during the preceding summer had his first attack of asthma with bronchitis. On February 26th he was taken with what seemed an ordinary cold, but by evening he was much worse. The cough, dyspnoea, inability to lie down, aggravated very much by the nasal catarrh obstructing nasal respiration led to the prescription of ipecac 2x. On February 27th the child was no better. Physical examination showed characteristic râles. *Sambucus* θ was prescribed. Improvement began and cure was complete in four days.

CASE III.—Mrs. R., æt. 60. Very fleshy and polyæmic. Had umbilical hernia from injury. Previous history of spasmodic croup, laryngismus and asthma. For three nights had slept little if any because of great shortness of breath, panting respiration at times, severe cough, with little or no expectoration, and that tinged with blood. Temperature was 100°; pulse 96. In the morning, at time of visit, felt comparatively well. Physical examination revealed nothing but characteristic

râles, notably on left side of chest. R. Antimon. arsen. 2x. This remedy not accomplishing what was expected of it, ipecac. 2x. was given in alternation with it. There was but a slight improvement. The rattling in the chest, however, became greater, breathing audible to those in the room and cough persistent with scant expectoration. R. Sambucus θ . Marked improvement then set in, and the patient was well two days later.

CASE IV. — Woman, æt. 60 years, of lax fibre mentally and physically. Thought she was threatened with pneumonia. The absence of chill, slight fever, temperature being 100.2° , the lack of all physical signs of lung mischief, were evidence of the neurotic character of her disease: Sambucus θ was prescribed and in forty-eight hours improvement was sufficient to permit her riding to her home.

CASE V. — Baby, æt. 11 months, presenting an asthmatic family history, and a personal history of repeated attacks of the catarrh of the respiratory tract. The paroxysms of dyspnoea were extreme. The child was listless, had no desire for food, and the breathing was evidently asthmatic. Examination of the chest determined no general dulness, only a superabundance of loose mucous râles, audible at some distance from her. Sambucus θ was given as in the other cases, and in one week the difficulty was gone. — *N. E. Medical Gazette*, December, 1892.

POTASSIUM META SULPHITE. KSO_2 . — The disease, its actual seat, even being unknown, homœopathically guided by the symptom of pain only, cures. A poor fellow, aged 35 years, had for many years past been subject in the spring and autumn seasons to weeks of acute pain in the lower abdomen, for which purgation and anodynes had hitherto been the routine treatment, together with confinement to his bed. His trade occupation, that of a blacksmith, necessarily threw considerable strain on his abdominal muscles, and thinking that this was the cause of his disorder, he was advised by his club doctor to give up his trade. Still the old trouble returned at the usual seasons. Experience of the curative power of the above medicament upon my own person in abdominal pains, profuse urination, prolapsus ani, stool of immense calibre, constipation, etc., suggested this kali sulphite; 6x trituration acted like magic. For two years the man has been free from his old agony, one single dose, being, when necessary, a veritable prophylaxis. — *The Homœopathic World*, November, 1892.

SOME DOLICHOS VERIFICATIONS. — Miss I., æt. 18; slight tonsillitis during gripe epidemic.

Pathogenetic Symptoms. — Sore throat, with but slight objective disturbance; right tonsil a very little reddened; severe sticking pains on swallowing, like a splinter, in, below, or sometimes behind the right tonsil.

Mr. Y., æt. 53, married; pruritus for two years.

Clinical Symptoms. — Intense itching on legs, worse on undressing at night, worse by scratching.

Remarks. — No rash on legs; no tendency to eczema; general health excellent; itching relieved in a few days; returned occasionally, but less severely; after a month was relieved permanently; no return in four months.

Mrs. Z., æt. 62; eczema vulvæ; invalid for years with mitral insufficiency and cardiac dilatation; chronic bronchitis; scrofulous constitution; eczema of many years' standing.

Clinical Symptoms. — Intense itching of eczematous region, worse at night and by scratching.

Remarks. — At first dolichos relieved the itching, and as the patient was able to keep her hands off, the eczema healed and is now practically well. Treatment carried on irregularly for four months on account of intercurrent heart and pulmonary trouble. All local treatment discarded, as dolichos did all that was necessary. — Dr. E. V. Moffatt, in the *North American Journal of Homœopathy*, November, 1892.

TREATMENT OF LARYNGITIS. — Dr. Jose A. Fontela, of Montevideo, S. A., outlines the treatment of laryngitis as follows:

Aconitum. — Four to thirty drops of the mother tincture, according to the age of the patient, as a daily dose, and one dose every hour.

Spongia. — When there is hoarseness, hollow and whistling dry cough, with burning and tearing pains, and a sensation as if the throat were obstructed. The respiration is difficult, with attacks of suffocation principally during sleep. Give the first trituration every hour.

Hepar Sulphuris. — Sensation as if there were a foreign body in the larynx, or as

if a cord constricted the throat. Violent attacks of coughing, suffocation and vomiting. A deep and dry cough is also noticed in the provings, but clinical observation has remarked it to be better indicated in a catarrhal cough. Dose, the first trituration, as with spongia.

Phosphorus, after Aconitum.—The symptom chiefly indicating this drug is excessive pain in the larynx on coughing, talking or breathing. Dose, two drops of the sixth decimal dilution every two hours.

Apium Virus.—This drug is employed in the third trituration, which has given us good results when there was great cedema.

Moachus.—Attacks of suffocation. This is merely a palliative. Dose, one and a half grains of the 1x every fifteen minutes or hour, according to the intensity of the attack. If the child will not take a powder, then administer it in water.

Stridulous Laryngitis—Ipecacuanha.—This is the traditional remedy, used as an emetic. It clears up at once and relieves the condition, curing the disease. For the benefit of the patient, as well as for the honor of our school, it is to be prescribed in emetic doses where the action is perfectly homœopathic. If we fail to do so we deprive ourselves of a valuable agent, and allow our adversaries to show themselves superior. Give a dose of the syrup of ipecac, a teaspoonful to a soup-spoonful, every quarter of an hour until vomiting sets in.

Moschus.—In doses of one and a half to two grains of the powder, first trituration, in water, this remedy acts well in the asphyxia. It relieves promptly the constriction of the larynx and suspension of respiration. Hughes advises olfaction as the best means of relieving the attack.

Cuprum.—An excellent remedy in spasm of the glottis. Hughes recommends it in a cough with suffocation. Dose, the third trituration.

Corallium rubrum, gelsemium and sambucus are drugs that present symptoms suggesting of spasm of the glottis, and many physicians prescribe them, with success, in the treatment of spasm of the glottis, stridulous laryngitis. *Sambucus* is indicated in asphyxia with cyanosis, suffocating cough: with whooping in children; nocturnal attacks of suffocation. Dose, in *corallium rubrum*, the 30x; in the others the first attenuation or the tincture are used.

Chronic Laryngitis.—The diathesis of this affection may be syphilitic or tuberculous. *Nux vomica* and sulphur, used alternately, constitute an efficacious treatment of chronic laryngitis in hæmorrhoidal patients. *Nux* suits more the hoarseness that is liable to pass into aphonia. There is a dry cough, coming in short succussions, and sometimes followed by expectoration of translucent mucus, which may be associated with a sensation of excoriation in the larynx. The indications for sulphur are more or less the same, only that the sputa is thicker and bitter. Dose, *nux* in the evening and sulphur in the morning, from the sixth to the thirtieth dilution. This treatment is to be followed for eight days, and then followed by an interval of eight days of rest.

Carbo Vegetabilis.—This remedy is somewhat analogous to *nux* in its action. It is indicated when there is considerable hoarseness, dryness of the larynx and absence of pain. This hoarseness approaches aphonia, especially at night. Complete aphonia, without remission, is like that from paralysis of the vocal cords, and is a certain indication of *carbo vegetabilis*. Meyerhoffer suggests this remedy in patients that have passed the fiftieth year, in whom the disease is associated with dilatation of the venous capillary vessels of the pharyngeal and laryngeal mucous membrane. Dose, from the twelfth to the thirtieth, in two daily doses, for twelve days.

Kali Bichromicum.—This salt has been employed especially by Meyerhoffer. The hoarseness, with excoriating pains in the larynx, cough excited by tickling, especially where there is a tenacious sputa. The first is the trituration recommended.

Kali Hydroiodicum.—Meyerhoffer uses this remedy in chronic laryngitis where the cough is dry, without expectoration. The first trituration is the attenuation.

Causticum.—Hoarseness even to aphonia, especially in the morning, associated with a scratching pain and actual pain. The cough is dry and hoarse. Dose, from the sixth to the twelfth.

Hepar Sulphuris.—Transient hoarseness; cough, with a bitterish expectoration; sensation of constriction in the throat and pain in the larynx from speaking or coughing. The first trituration is the attenuation recommended.

Manganum.—Hahnemann spoke highly of this drug in laryngeal phthisis, but it has always been employed, nevertheless, in chronic laryngitis. Its symptoms are:

hoarseness, especially when the patient is in the open air; dry cough, excited by talking, and accompanied by dryness and constriction of the larynx; greenish expectoration. This drug is especially suitable in herpetic patients. Dose, the lower triturations, one and a half grains, twice a day for several weeks.—*Bulletin de Homœopatia*, No. 5, 1892.

DR. MACFARLAN'S PROVINGS WITH THE HIGH POTENCIES.—*Hyoscyamus*^{cm.}.—Cured permanently a child which would sob and cry a great deal at night in her sleep without awaking; chronic symptom, slight ague like chill every other day at eleven o'clock, with fever and sweat. In several provers caused *stupefying headache* continuously; cannot bear the least noise or to be talked to; eyes sensitive to light.

Iodine^{17m.}.—Nose discharges clear mucus; considerable fever; no appetite; hot, dry skin all day long; creepy sensation; face fiery red; pain in occiput and temples; teeth sticky with adhesive saliva. Promptly curative in the marasmus of a child thirteen months old, who had with it a moist eczema about the anus and inside of thighs, and aphthæ. Creosote was given later in case there was a disposition to diarrhœa.—*The Homœopathic Physician*.

NOTES ON ACONITE.—The pains of aconite are sharp, sticking, piercing in character.

Aconite is especially valuable in cases of convulsions produced by fright.

In cases of hæmorrhage of the bowels from fright, *nux moschata* is frequently indicated.

The menses, under aconite, are suppressed from shock, fright, or from exposure to cold.

Anxiety expresses the mental condition of aconite, while the restlessness, flushed face, excitement, and thirst are characteristic.

Aconite is worse than useless in intermittent and typhoid types of fever. The fever of aconite is continuous, sthenic, neurotic in character.

Gonorrhœa may be aborted by aconite often in the initial stage. The progress of the disease may be cut short if aconite is given on the exhibition of the first symptoms.

Millefol. and aconite both have hæmorrhages from the lungs. In both the blood is bright red and thin, but aconite has its characteristic mental symptoms; the *millefol.* patient does not display the great anxiety.

Aconite affects first the sensory then the motor nerves; when applied locally it produces a tingling sensation followed by numbness. The action of aconite is from without inward; the reverse is found under opium.

Under aconite is found an epistaxis the result of fright, always associated with excitability, an active hæmorrhage, the blood is bright red and hot. Other valuable remedies for epistaxis are *carbo. veg.*, *ham.*, *secale*, *crocus sat.*—*The Chironian*, November 20, 1892.

NATR. SULPH. FOR DIARRHŒA.—Diarrhœa for a year in a woman of full habit. The only symptom that could be elicited was the fact that the diarrhœa came on after rising in the morning. A dose of *natr. sulph.* 3 was given four times a day, and in one week fecal movements became normal.—Dr. George M. Ockford, in the *N. A. Journ. of Hom.*, November, 1892.

KALI SULPH. IN MEMBRANOUS CONJUNCTIVITIS.—This remedy has lately given me most satisfactory results in three or four cases of ophthalmia neonatorum, characterized by a closely adherent membrane on the palpebral conjunctiva and a thin yellowish or sanious discharge. I give two of the cases; the notes of the others were, unfortunately, not preserved.

Baby G., male, æt. 9 days. Began with snuffles and "watery" discharge from the eye, which had become thin, then thick yellow, and finally sanious, with membranes on the palpebral conjunctiva. After failure with other remedies, *kali sulph.*, iii. trit., cured promptly.

Baby F., male, æt. 14 days. Eyes suddenly discharged yellowish pus. Brushed with nitrate of silver solution and gave *arg. nitr.* 3. Next day, worse and membranous, with much swelling of the lids. *Brom.* 3 internally, and H_2O_2 locally, did no good, neither did *comp. tinct. iod.* internally. *Apis* mitigated the swelling, but the discharge became viscid; *kali bich.* made it more watery, and under *kali sulph.*, iii. trit., all the symptoms improved rapidly, with vision unimpaired.—Dr. John L. Moffatt, in the *North American Journal of Homœopathy*, October, 1892.

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TREATMENT OF HÆMATURIA.

BY CLIFFORD MITCHELL, M.D., CHICAGO, ILL.

HÆMATURIA being in most cases a symptom of a general condition no great effort has been made to direct attention to its special treatment.

Writers will comfort their readers with the general statement that removal of the cause is the thing to attempt. This is indeed true, but it may take weeks or months to remove the cause or perhaps even to discover it, and in the meantime the patient, like Marco Bozarris, "dis, bleeding at every pore!"

A synopsis of that which is scattered about medical literature with reference to hæmaturia, even if it be neither wholly new nor altogether complete, may be of use in a time of trial.

I. TREATMENT OF URETHRAL AND PROSTATIC HÆMATURIAS.

In general, simple or bread-and-milk diet, rest, bowels free, injections of hot water or of hot boric acid solution, three or four per cent.; application of Faradic electricity; electric baths. For constipation, if any, Rubinat water. If the urine turns blue litmus paper noticeably red, cause the patient to void urine on rising in the morning, to eat breakfast at usual hour, and to save urine voided at 10.30 A.M. This last urine is to be tested with blue litmus paper; if the

blue paper is turned red there is hyper-acidity, since normal urine is but feebly acid or alkaline at this hour in the day. In such a case keep patient on bread-and-milk diet, give alkaline waters, as Buffalo or Londonderry, and lithium benzoate in doses of one-half to two grains, three or four times daily, to overcome the acidity.

If the hæmorrhage is from the prostatic urethra, stricture, if present, must be overcome, and if there is constipation with straining at stool, this must be attended to. If the endoscope shows fissure, astringent injections may be used. (See list below.) For spasm of the bladder, morphine in suppositories or hypodermically may be necessary. If the hæmorrhage from the neck of the bladder be profuse at any time, introduce a soft catheter and let it remain. In obstinate, dangerous hæmaturias from the prostatic urethra, introduce a Nélaton bougie, fasten it by tying around the penis and let remain for twenty-four hours at a time. Apply ten per cent. solution of silver nitrate, as suggested by Dr. C. D. Rich, per endoscope to the bleeding areas.

In the case of old men with hæmaturia and enlarged prostate, avoidance of cold and fatigue is to be enjoined, and fluid extract of saw palmetto in teaspoonful doses four times a day to be tried. Dr. A. B. Späch reports complete cure in one such case, so far as the hæmaturia was concerned, by the use of this drug.

If the bladder becomes distended with blood, *do not use catheter as long as patient is able to void urine*, but keep him quiet and give opium and ergot. When complete retention ensues, use catheter but with most scrupulous antiseptic precautions. If even after catheterization, the bladder is not quieted and clots are still present, break up and remove the clots gradually by careful and frequent antiseptic washing, or, if necessary, by use of the lithotrite as suggested by Bangs. If the hæmorrhage still continues and is not controlled by dilute astringent injections, a drainage operation, preferably by the perinæum, is to be undertaken.*

If hæmorrhages from the urethra depend on injuries, inflammations, or urethral chancre the general directions given above for diet and regimen hold true, and in addition, there is required the treatment for the condition on which the hæmaturia depends.

II. TREATMENT OF CYSTIC HÆMATURIAS.

The hæmorrhage is due to congestion, inflammation, foreign bodies, new growths, or injuries. In ordinary cystic hæmorrhages

* Bangs, *op. cit.*

due to congestion or inflammation empty the bladder with a thick Nélaton catheter and inject cold water or ice water till the hæmorrhage ceases. Keep patient on his back and use ice to the perinæum, hypogastrium, and in the rectum. In severer hæmorrhages keep patient quiet, giving opium and ergot as suggested before.* If the clots cause retention, empty the bladder by catheter and use astringent ablutions. Finally, if bleeding still continues, fasten a thick elastic catheter with large openings, the open end dipping into five per cent. carbolic acid solution, and make cold water injections every ten minutes.

In hæmorrhages due to stone, rest in bed, and removal of the stone. Until removal of stone carefully wash out the bladder, and if necessary, inject two per cent. solution of tannin, or zinc sulphate half grain to the ounce.

Hæmorrhage of the bladder is sometimes due to rupture of varicose veins especially in elderly patients; for this condition try tincture of St. Mary's thistle (*Carduus Marianus*) in thirty-drop doses, three times daily and see also list below.

In hæmorrhages due to papilloma, which are often long-continuing, use injections into the bladder of silver nitrate, 1 in 500, and when the patient becomes less sensitive, 1 in 200.†

Hæmorrhage from papilloma in the bladder recurs usually only at very long intervals, often of a period of years; sometimes the only symptom is the occurrence of repeated and prostrating hæmorrhages, the blood being so intermingled with the urine that the cystoscope is of no service in the diagnosis, which is made by examination of the patient and of the urine, by the resorption test, etc. Incision into the bladder and removal of the tumor by the supra-pubic operation will stop the hæmorrhage (Bangs).

In hæmorrhage from injuries to the bladder, rest, quiet, careful ablutions, and, if necessary, an injection of two per cent. solution of tannin, or zinc sulphate solution half grain to the ounce.

III. TREATMENT OF RENAL HÆMATURIAS.

In general, in cases of renal hæmaturia, if the bleeding become serious, absolute rest in bed is enjoined in a horizontal position, while the pelvis is somewhat raised. Ice-bags may be applied to the vicinity of the kidneys.

* Ultzmann, *Krankheiten der Harnorgane*, Vienna, 1888.

† Ultzmann, *op. cit.*

If the case be one of post-scarlatinal or other acute nephritis, the general treatment for that disorder should be observed,—non-nitrogenous diet; pure water, as Poland or distilled; rest and quiet; bowels opened once daily by warm water enema. In the early stages, if there is coated tongue, sluggish condition of the bowels, etc., give *merc. cor.*; for the dropsy, rest and diuretin, in doses for children, two to five years, two to six grains four times daily, dissolved in warm water; for children six to ten years, six to twelve grains; for adults, fifteen to thirty grains.

In chronic Bright's disease, renal hæmaturias are found in cases of the large mottled kidney, occasionally in cases of atrophied kidney, and in acute nephritis supervening in cases of chronic syphilitic nephritis. If the loss of blood is considerable, try such remedies as *hamamelis*, *ipsecac*, *geranium*, *trillium*, *gallic acid*, *terebinth*, *secale*, *ferrum* (see list below).

In the hæmaturias of renal calculus* the remedies are *cantharis*, *terebinth*, *uva ursi*; if serious loss of blood, *gallic acid* or *ergot*; *pichi*, the latter in doses of ten to thirty minims of the fluid extract.

In the hæmaturias from carcinoma, complete rest, cold applications to lumbar region, together with *hamamelis*, *secale*, *ferrum*, *ipsecac*; ten-grain doses of gallic acid every four hours, with ice to abdomen applied in a bladder; flannel roller; enemas for constipation; gently wash out bladder to remove clots and coagula. Hæmaturia alone is not regarded as a positive indication for a nephrectomy in cases either of cancerous or of tuberculous kidneys.

In cases of calculous hæmaturia, with symptoms of recurring lumbar pain, preceded, accompanied, or followed by hæmaturia, the cystoscope showing whence the blood is derived, judicious nephrotomy may be done. Failures to find renal calculus are sometimes due to caution in making a wide enough incision (Bangs).

If the renal hæmaturia be due to malarial toxæmia, the hæmorrhage may sometimes be of long standing, covering perhaps a period of years. There may be no aggravation from movements, and pain in the lumbar region may be absent. Examine the blood taken from the patient's finger for *plasmodium malarie*,† and, if found, treat the case accordingly. Give Rockbridge, Bedford, or Oak-Orchard water, and try electric baths. Internally, *hamamelis* in ninety-minim doses; *arsenicum*, *ferrum*, *ipsecac* or *china*, according to indications.

Cases of renal hæmaturia, due to alteration of pressure in renal

* Removal of the calculus, either by medical or surgical measures, is, of course, to be recommended.

† Bangs.

capillary circulation, have been chronicled. The symptoms are as follows :

Urine uniformly bloody, but of normal quantity ; hæmorrhage of long standing ; *patient better in summer than in winter* ; easily fatigued and weak ; marked constipation and loss of appetite. Treatment is to open the bowels and give vapor baths.

One curious case of hæmaturia in a boy, reported in *Sajous' Annual*, was found to be due to eating pie-plant in excess and drinking hard water. Crystals of oxalate of lime were formed, and the irritation from them caused the bleeding, which ceased when the diet was regulated.

Renal hæmaturias may be due to poisoning by drugs as turpentine, to injuries, and to typhoid intoxication where it follows the high temperature, disappearing on the fall of the fever. Subcutaneous or intra-peritoneal injections of boracic acid have been known to provoke hæmaturia.

Vicarious menstruation by the kidneys has been noted,* and also spontaneous and even regular monthly hæmaturia in males. In one case of the latter, gallic acid effected a cure.

Hæmaturia, due to injuries of the kidney, with collapse and signs of great loss of blood in region of the kidney may require incision either lumbar or abdominal, and ligation of the great vessels of the kidney.†

In hæmaturia in women, look for movable kidney, which is sometimes a cause, and if out of place, replace with bandage and pad. In regard to the diagnosis of movable kidney, Keen says: "Given a movable tumor in the flank, which can be displaced into the iliac fossa, or even beyond the median line, which can be pushed back into the position of the kidney, and which has about the size and shape of a kidney, the diagnosis is clear." Wilcox advises the manual examination to be as follows: Patient to lie on back and exhaust air from the lungs. Examiner presses fingers in deep so as to get them below the lower edge of the kidney. Then keeping the hand in place, the patient inhales and thus forces the kidney down into the grasp of the examiner. The only curative treatment is operative, and nephrorrhaphy is, according to Wilcox, preferable, except in diseased kidneys, to nephrectomy. Patients with movable kidney are subject to sudden attacks of abdominal pain, feeling of anguish,

* Lebec in *Sajous*, 1890.

† Bangs.

vertigo, vomiting, and fever; colicky pains during micturition, frequent desire to urinate and slight polyuria.

Hæmaturia is rare in cases of movable kidney.

A FEW HÆMOSTATICS, WITH DOSE.

Alum, 10 to 20 grains; acetate of lead (equal parts with opium), 1 to 2 grains; aromatic sulphuric acid, 5 to 15 minims; carduus (tincture), 30 minims; creosote, 1 minim; ergot, normal liquid, 5 to 20 minims; ergot, fluid extract, 20 to 60 minims; ergotine, subcutaneously, 1 to 5 grains; "ergotole," 5 to 30 minims; "ergotole," subcutaneously, 5 to 20 minims; gallic acid, 10 grains; geranium (fluid extract), 30 to 60 minims; hamamelis (fluid extract), 60 to 120 minims; iron (tincture of chloride), 5 to 20 minims; lead and opium (equal parts), 1 to 2 grains; matico (tincture), 60 to 480 minims; opium and lead (equal parts), 1 to 2 grains; tannic acid, 10 grains; terebinth, 5 to 30 minims; trillium (tincture), 30 to 60 minims.

ASTRINGENT INJECTIONS.

Alum, one-half per cent.; zinc sulphate, one-quarter per cent.; zinc carbolate, one-quarter per cent.; potassium permanganate, one-fifteenth per cent.; tannic or gallic acid, two per cent.; silver nitrate, one-tenth per cent.

Favorite mild astringent injections are gallic acid, 2 per cent., and zinc sulphate, one-half grain to the ounce.

MISCELLANEOUS NOTES ON HÆMATURIA.

I append a few stray notes on hæmaturia in general, which may possibly be of service for reference:

1. Laceration of the kidney may occur without external appearance of injury, in cases of accident; the symptoms are hæmaturia, pain in the loins, possibly pyuria, typhoid condition, and death in a few weeks.

2. Keyes* reports several cases of hæmaturia in connection with enlarged prostate in which tube-casts and much albumin were found in the urine. The conditions were such, however, that the diagnosis was readily referable to the prostate and not to the kidney primarily.

3. Kinnaird,† in a case of chronic cystitis from chronic enlarge-

* *Medical Record*, October 31, 1891.

† Paper at Central Kentucky Medical Association, July 21, 1892.

ment of the prostate, attended by alarming hæmorrhages from the bladder, performed supra-pubic cystotomy with immediate relief to the patient.

4. Reginald Harrison reports that in 100 cases of hæmaturia the causes were as follows: renal calculi, 30; enlarged prostate, 20; vesical calculi, 14; tumors, 13; tubercle, 6; urethral stricture, 5; non-prostatic cystitis, 3; passage of calculi through ureter, 3; traumatism, 2; filaria, 1; doubtful, 3.

5. Ginard* points out that an alternation of clear and bloody urine in the same day is never seen in hæmorrhage due to tumors of the bladder.

6. L. Bolton Bangs in a paper read at the meeting of the Surgical Section of the New York Academy of Medicine, November 2, 1891, records a case of hæmaturia in which the history and symptoms were those of papilloma.

In cystoscopic examination, although together with irrigation, nothing but the appearance of a dull red fog was obtained. The bladder being opened by the supra-pubic method, no salient tumor was found, but on the base of the bladder was an area occupied by granulomata from which blood exuded. Hæmorrhage returned two weeks after operation (curetting, cauterizing, and use of iodoform tampon), but yielded finally to hot water irrigations.

In another case in a young woman of eighteen with a history of frequent urination and for years uncontrollable nocturnal enuresis, there had been hæmaturia for a month or so. Urine at first intermittently bloody, finally continuously. No pain. Patient anæmic, weak, and not well-nourished. Cystoscope showed irregularly shaped patches of a grayish-white or pearl-colored infiltration of the posterior wall and base of the bladder, covered by little clots of blood. The patches were removed (supra-pubic operation) by the scissors, curette, etc., and found to be sarcomatous in all probability. Patient at end of one year in fair health.

7. According to Rayer† the urine voided three hours after eating is sometimes more than ordinarily bloody, in cases of calculous pyelitis or cancer of the kidney.

8. If blood has been retained in the bladder for a considerable time, the urine may be colored almost black by it.

9. Blood from the seminal vesicles will be clotted, and mixed with

* *Archives Générale de Médecine*, October, 1891.

† *Maladie des Reins*, quoted by Keyes, *Genito-Urinary Diseases*.

yellow bodies and spermatozoa. When the spermatic fluid in sexual intercourse is bloody, the blood probably comes from the prestatic sinus.

10. Cystic hæmorrhage may be due to overdoses of cantharides.

11. Symptoms of malarial hæmaturia sometimes resemble those of stone in the bladder, viz.: frequent and painful micturition, vesical tenesmus, sacral pain, and sleeplessness; rigors usually daily, fever, and sweat for several hours and beginning usually at the same hour are, however, characteristic of malarial hæmaturia.

Dr. Dudgeon speaks of thlaspi as a hæmostatic, as does also Rademacher. The latter gave tincture of thlaspi bursa pastoris in thirty-drop doses five times a day for the hæmaturia of uric acid gravel with complete success.

Dr. Heubach, assistant to Professor Zuelzer, reports a case of hæmaturia due to uric acid gravel, cured by piperazine. The patient was a lady of fifty, who for years had passed bloody urine loaded with uric acid gravel. Ten days after the administration of a one-half per cent. piperazine solution, tablespoonful every two hours, profuse elimination of small roundish uric acid calculi took place lasting several days; afterwards the colicky attacks and hæmaturia ceased.

ARBORIVITAL MEDICINE.

BEING AN INQUIRY INTO THE CURATIVE POWERS OF SOME OF
OUR COMMON FIELD AND GARDEN PLANTS, JUDGED
OF BY THE DISEASES OF THE EAR.

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(Continued from January, 1893.)

We wish this investigation to proceed upon observations based upon fact alone; but facts necessitate theory. Thus, we theorize when we assume the operation of a growth-force in the changes brought about by disease by single doses of herbal remedies; and our reason for this assumption is, that we are cognizant of no other force in vegetable fibre that could possibly be assumed to act in such small quantities as we are in the habit of giving.

In like manner we consider it allowable to theorize as to the non-repetition of the remedy. The necessity for this we assume to be from the presence of its own antidote in each remedial agent. For example, if we wish to correct a constipation by opium, and with this object in view administer a dose every morning, and at the end of six or seven days we find the constipation no better; and if to the same case later on we give a single dose in the early morning, and allowing it to act, make a record of the patient's condition seven days afterwards, and if, at the end of this time, we find distinct and positive relief to have resulted, we have, I maintain, as strong evidence as clinical experience can afford of the superior efficacy of the single dose. Cases like this are most certainly of constant occurrence, though this one is hypothetical.

What, then, retarded the action of the opium in the first instance and allowed of its full influence in the second case? I hold, though quite open to correction, that the superiority of the action in the second instance is attributable only to the presence in the drug of its own antidote. As to the way in which this antidote acts, a word or two is allowable.

Hahnemann contended that many drugs acted from four to six weeks, and even longer; but to such statements as these very little credence is given nowadays by his followers, seeing that the majority of them repeat medicines quite as often as, if not oftener than, the allopaths themselves.

But it concerns us not whether credence has been given to this idea; the question for us to consider is, is it true? A single dose of such medicinal substances as I am in the habit of giving—tinctures of fresh plants—will certainly leave its stamp upon the reaction that follows, and evidence of action having resulted from a particular drug will crop up from time to time long after its first administration, this being as strong evidence as it is possible to obtain of the truth, that drug action, if carefully watched, is found not to be expended in the early disturbances occasioned. The first effect of the well-selected drug is to give, in homely language, a turn to the disease, a reversal in the vicious rotation set in motion by the disease; and this force having once corrected or otherwise altered perverted movement, the efforts of the organism are aroused to continue the curative tendency, supposing it to have been thus started.

Hence the necessity for not interposing a second drug or even a dose of the same drug, some of the particles of which may operate to the detriment of the beneficial action already commenced.

How can we tell that a dose that has commenced acting beneficially upon the disease will not be neutralized by a subsequent one ; in other words, how do we know that the subsequent dose is not expending its energy in counteracting the influence set agoing by the first dose ; or, to put it in another way, how do we know that the second dose is not acting more upon the disturbance created by the medicine than upon that originally induced by the disease ?

Remember, we are not now considering tangible forces, such as the irritating action of croton oil or rhubarb, and which are to be gauged entirely by considerations of the amount of material exhibited, the frequency with which the dose is repeated, and according to some, to a certain extent, to the gross weight of the animal's body.

We are referring to the effects of the imponderable force or forces of plants ; and when we use the word antidote, we do not mean that which will materially neutralize the properties of the plant-substance, but that which will counteract the effect of the subtle forces displayed by the plant.

Then, regarding the selection of the indicated remedy : Hahnemann was strong upon the point that herbal remedies allied to each other in color, form, habitat and habit may have and generally do have widely different effects.* Alas ! though, for the fact ; for his own followers rarely use the kind of bryonia he introduced, and that his chamomilla, pulsatilla and euphorbium were the same remedies as are often nowadays used under these names, there are, to say the least, the gravest doubts. Professor E. M. Hale, of Chicago, has seriously stated that all varieties of cactus act upon the heart, and all the evidence we have points to there being a great similarity between the actions in disease of plants having similar habits and forms, and which are species of the same botanical natural orders.

From this we infer that if we approximate to the right selection ; that is to say, if we select a plant of a species, one of the varieties of which has been known to cure a like train of symptoms to that for which we are prescribing, this plant will, very probably, if given in single dose, cause equally a dispersal of the symptoms.

This statement will, of course, stir up the wrath of all true Hahnemannians, but it cannot be controverted by any array of facts worth consideration, though, indeed, it is gravely controvertible upon theoretical grounds.

* *Materia Medica Pura*, vol. ii., Hahnemann Publishing Society, p. 15, London, 1881.

The fact I imagine to be that drugs consist of various forces, each of which has its own department in the work of growth, and similarly each its own action in the work of cure, and that if a single dose be given, the work of what may appear to be subordinate forces comes into play later on when the dose is allowed to act. Thus, I give a dose of opium procured from the fresh plant of *papaver somniferum*, and it relieves constipation in half an hour; at another time I give to the same patient a drop of our field poppy, *p. rhœas*, and in four hours the patient is relieved. In both instances the opium has acted, but there was a force in the Turkey opium more powerful for the purpose, which force was represented in the plant by a principle predominating over the other principles; while in our indigenous preparation the predominating force was different; and so, though it existed, it was not in ascendancy, consequently it had to come into play after some other whose influence was different. Thus, both plants being nearly allied remove the same symptom, though the one requires longer to effect the required purpose, and thus I conceive it to be with a large number of allied drugs.

It is impossible to state with accuracy the length of time over which a single dose will act. Hahnemann, in his prefatory remarks to provings, assigns different lengths of time for different drugs; thus, with *ipécacuanha*, he states it acts for but a short time, in large doses hardly a couple of days, in quite small doses, about a couple of hours; while for *euphorbium*, he gives the duration of its action as seven weeks; and of *daphne mezereum* as from forty to fifty days. Without at all questioning the accuracy of statements of this sort, as applicable to each individual remedy, it must be confessed that very little use has been made of them in homœopathy. I question very much whether any Hahnemannian is in the habit of repeating doses of *ipécacuanha* oftener than those of *mezereum* or *euphorbium*; and certainly, practitioners who are not strict followers of Hahnemann are in no way exercised by such statements.

All my own observations upon the actions of remedies go to show that if a remedy that is suitable for a certain train of symptoms be selected, and if it be given in single dose, the duration of time over which this single dose will act will depend more, a great deal, upon the age of the patient, and the previous duration and obstinacy of the disease, than upon the individual characteristics of the remedy.

In very old patients, afflicted with progressive deafness, of the vascular description, there is no hope whatever of improvement in the hearing, unless the dose be allowed to act for several weeks to-

gether; and this applies equally, as far as I can observe, to all remedies; whereas, in young patients benefit is, sometimes, derived by repetition of doses at intervals of ten days, or perhaps a week.

I have used two kinds of anemone, other than the true *pulsatilla*, and both of these, *anemone fulgens* and *anemone pulsatilla* (not *pratensis*), I find to exert a strong influence upon the catamenia, and also to act largely upon the ear. Many other like instances of similarity of action might be given, notably, in the case of *sabina* and *thuja*, which are supposed to exert a very dissimilar effect; all I can say is, that I have not been able to detect any difference in their action, externally or internally, when applying them in disease, and it is above everything misleading to assume accuracy, or any other virtue, when we have it not.

It will, of course, be objected that this is a very loose way of looking at the matter. It is so, indeed, but it matters not to me so long as it is consonant with fact. There are, in every department of disease, hosts of the uncured, and there are hosts of remedies provided for us by nature; this will not be gainsaid. Why, then, reject a mode of proceeding that offers benefit all around for no better reason than that it is loose and inexact? In the commencement, we have, in all investigations, to make statements based upon broad and often ill-defined facts, before we obtain that minute, exact, and precisionized evidence so necessary for the building up and completion of a science. But curative medicine is not, and never has been, a completed science, nor anything like completed; we are only on the verge of inquiry, and particularly so in regard to this present undertaking, which starts with the acknowledgment, and whose *raison d'être* is, in consequence, of insufficiency of knowledge.

Attempts have been made to elaborate systems of medicine as offshoots of homœopathy. Dr. Sharp, of Rugby, is a notable and worthy example of one who has, under the term "Organopathy," made the attempt. But I am not aware that Organopathy has added to our armamentarium of remedies a single drug, or has in any way altered our mode of administration or preparation of drugs. Still, it was an honest and scientifically conceived method of improving the fundamental principles of our therapeutic system.

Dr. Schüssler, too, has professed to improve matters by presenting us with twelve tissue remedies, which are supposed, if properly administered, to effect all that it is possible to do with drugs. Whether Dr. Schüssler retains an interest in the sale of his remedies or not, I have no means of knowing, but certain it is, that these are being

disposed of very freely as his remedies, and that pecuniary interests would appear to require an advocacy of these twelve preparations, which, to say the least, is gravely compromising in this golden age.

Like objections are applicable to the excessively high dilutions of some American writers, these being freely disposed of by the medical men recommending them.

We need hardly refer, in this connection, to the admittedly quack systems of Mattei and others, all of which were begun and continued, and are being carried on, for commercial purposes. The temptation to establish a market for remedial preparations is very great, and the want of really curative preparations is so wide-spread, that with anything like care such enterprises are sure of success; but in the eyes of the scientist all such undertakings are regarded from the first with suspicion; they stand self-condemned, and should be in every way distrusted.

The idea with which, in this investigation, I start is, that we are surrounded with thousands of remedial agents that, with a little patience, the actions of these are easily discoverable, and that every medical practitioner ought to be the preparer of the greater portion of his own medicaments—of, for example, the tinctures, for the preparation of which I have already given directions, which are, by far, the most available forms for general exhibition.

This brings me to the question of the use of external remedies. Does the application of the medicament, whether in the form of ointment or otherwise, to the external skin, act with greater force upon single application, or is its continued exhibition needed for purely curative purposes? Upon this question I have at the moment of writing no facts by me that would in any way justify an expression of opinion, and beyond saying that I do not see any objection to the external application of simple remedies, such as glyceroles of one drug, or of vaseline or lanoline similarly medicated, I wish to be silent. A circumstance was vouchsafed to me lately by a very intelligent gentleman which I think illustrates the advantages which may be derived from an oleaginous preparation of a drug. A lady, middle-aged, a member of his family, contracted a swollen and hard breast which took on ulceration; her medical man was in despair and advised removal. An old woman working in the house expressed a wish to see it, and on inspection volunteered its cure in a few days. For this purpose she sent to Covent Garden for three pennyworth of green garden rue; this was worked up with lard and placed for a time in the oven; it was then applied to the breast, and although at first it

caused great pain, the application was persevered in, and in three days the entire swelling had gone down, as the old woman anticipated it would, and complete cicatrization took place. I have no means of ascertaining whether the nature of the swelling was cancerous, and beyond the information given am not in a position to supply further particulars.

From the description given of preliminary aggravation followed by cure, I am inclined however to think that one application followed by freedom from all further medicines would have sufficed, in the case related, for cure.

Such cases ought to make the Hahnemannian pause to consider whether he really obtains all the curative action present in the common herbs from his highly diluted preparations. His reply will be that, in such a case, *ruta graveolens* was the indicated remedy, and therefore effected a cure, which would have been brought about as effectually, and more painlessly, by a dilution of the remedy, and that this particular remedy was the one he necessarily would have selected from his repertory.

But he must admit that the old woman practitioner had no repertory, and he ought in justice to acknowledge the possibility of doubt as to whether this was the very remedy he would have chosen, and if he had chosen it, whether it would have been in his hands equally efficacious. And in such a way we might with very probable advantage discuss the rationale of the many cures we daily hear of as being made by our by no means unintelligent domestic practitioners.

In conversation with a friend the other day he narrated the following trite experience: One day in walking through a field with his gardener he observed him pluck a dandelion flower bud (*taraxacum leontodon*) and chew it, and on inquiry elicited from him that whenever his father had had any biliary disturbance, the one infallible refuge was the dandelion blossom; "And," said the gardener, "I have followed his example through life with the greatest benefit to my health." Seeing this, my friend proceeded to do likewise, for he was then suffering from a weight across the forehead due presumably to liver disturbance; and, continued my friend, "it is very remarkable, now that I think of it, that for the three months since then I have had no manner of head trouble, though before this I was very subject to such grumbly liver headaches. Perhaps," he naively added, "this is an example of the action of growth-force." Here then is a very simple and oft witnessed fact; let us see how scientific men utilize it. Dandelion is of course a familiar drug; let

us suppose it not to be so, and to be presented to the profession for the first time. The allopath will proceed by ignoring the details of the experience which first drew his attention to it; he will pulp the root, make pills of it, and will end by declaring dandelion to be a mild laxative of very questionable utility, and that "no effect is to be witnessed by a single dose of it." (Wood's *Therapeutics*, p. 425.)

The homœopath, on the other hand, will look askance at the gardener and declare himself unable to make use of any such experience, as he is not in possession of a proving of the drug.

But when he starts to prove dandelion he discovers he can get no symptoms worth consideration from repeated doses and material quantities of the plant, and when, thus thwarted, he institutes a proving with the high dilutions and single doses, and sends it off to a prominent *Homœopathic Monthly*, what is the encouragement the editors give him? Why, they will regard him as a nuisance, and will refuse to publish his high dilution proving lest it might make allopaths laugh!

This is what actually happened to the late Mr. Henry Robinson when he submitted provings of high dilutions, collected, as I have reason to know, with the greatest possible care; and this in face of the fact that he was looked upon by Dr. Constantine Hering as England's foremost prover.

So that as far as the procedure of modern homœopathy goes a remedy like dandelion has no earthly chance, and in allopathy it is retained only because the demand for it in shops, from the public direct, is considerable.

That I am not overstating the case, let me take this drug, dandelion, and call for a single cure that has been made by it in either the homœopathic or allopathic school during the last twelve months. I doubt if one could be produced; certainly not one outside of the high dilution school, though were one to tramp through the villages of England one would probably hear of hundreds. Can such things be without our special wonder?

Dandelion in fact illustrates very well the need there is for developing that phase of homœopathy we are pleased to term arborivital medicine; for, from all we know of its proving, it is a legitimate influence that it has been collected from single doses of a drop of the fresh juice, this being the dose actually recommended by Hahnemann in his preface to its proving, and collected too in a short space of time; and that the subsequent comparative uselessness of the proving is the result of its not having been prescribed in single doses and at sufficient intervals.

Inquiry, the more varied and the more independent the better, is called for at every stage in the progress of medical research, and the physician who throws aside as unworthy of consideration the experiences of the unlearned but observant will lose much for himself and for his patients.

We have seen that the individual members of the same family of plants have in most cases a very similar action upon disease. Now it is extremely desirable to avoid the continual drugging patients who are suffering from chronic forms of disease. The physician's work ought to be, as far as he can make it, wholly beneficial; and if in the nature of things it is not always given to him to command success, he ought to regulate the forces with which he copes with disease in such a way as to preclude the possibility of injury accruing to the patient. It goes without saying that *primum non nocere* has never been a recognized principle, or rather has never been acted up to in regard to remedial agents, save in the homœopathic school. Now it will occur at once to the reader that if we are limited to one dose at a time, the temptation, in case of failure, to repeat this dose will be very great, and in some cases it will be even insurmountable. Very true, but this is no reason why we should not aim at the more scientific and in every way the more desirable procedure. However, my reason for touching on the subject is to suggest, in case of failure of a single dose of a drug that appears to be well indicated, the exhibition of a dose of a plant allied to it in habit, in form and in other botanical features.

For the purposes of arborivital medicine it will therefore be necessary, as time goes on, to have in stock samples of the different varieties of the various plant families, and to use these as occasion may warrant.

The more I pursue inquiry into these matters, the more I become convinced that plants whose botanical features are very similar, are also very similar in medicinal properties. There is probably quite as much difference between a *reseda luteola* grown upon a limestone or granite soil and one grown upon a calcareous soil, as there is between the *lutea* and the *luteola* varieties of the same species. And while I would suspect a very great similarity of action between the *reseda luteola* and *reseda lutea*, as their habits are precisely similar, so would I suspect the indications for the *reseda odorata* variety to be quite different.

The first object in every prescription must be to cure the patient; scientific research has proved this to be best effected by a similarly

acting remedy. No investigator, whatever may be his school of medicine, can afford to forget this, however he may vilify homœopathy; it would be folly at this period of the world's progress to dispute it. This similarity is, however, not always provable previous to prescription; it may have to be proved later on. It is then evidence collected, subsequently to prescribing, of the drug's action, whether it acts in accordance with the law of similars or not, that we wish to secure; and we aim at obtaining this by observance of the disturbance which the remedy sets going in the diseased as well as in the healthy. This it will be said is exactly what Hahnemann protested against; I am aware of it, but as I said before, I can see no possible objection to it, and no possible way of avoiding it, when the nature of the disease is such as is outside of, or indifferently met by, the more unobjectionable method of prescription by means of a repertory. Moreover when I limit myself to the small dose, one drop of a plant at a time, the resulting disturbance, within reason, cannot possibly be such as to leave harmful consequences.

When then I search for a direct curative in disease, and when I acknowledge this to be in most instance a similar, and when moreover I give but a single remedy, it may be objected that this is simple homœopathy from beginning to end.

It differs from homœopathy, however, in exalting very greatly the utility of the single dose; in never repeating medicines in chronic cases at less intervals than a week or ten days for each dose; in discarding altogether as unnecessary the infinitesimal dose, though insisting upon a small one; in permitting the very free prescription of single doses of herbs of whose action we have no certain knowledge; in never preparing our tinctures from the roots, seeds or fruits of plants, but always when procurable from the living budding stalk; and in not aiming at the development of artificial powers in our preparations of drugs.

Such then is the object of arborivital medicine, and it only remains for me to again insist that it is in its early infancy, and that the few observations I am about to make upon some of our common plants are meant to be but the commencement of a series of reports which will be drawn up as facts present themselves.

The necessity for any divergence from the now well established methods of investigation into drug action introduced by Hahnemann can only be justified by its leading to improved results in the treatment of obstinate forms of disease, and by its revealing to us unknown or imperfectly understood properties of substances, espe-

cially of those that hitherto were not supposed to possess medicinal virtues.

How can any thoughtful man give credence to the supposition that a large department of the diseases that afflict humanity—the diseases of the ear—are incurable? Has not the same been said of all forms of chronic disease, and this even in the face of most striking and unmistakable recoveries which from one cause or another were of by no means infrequent occurrence? Can it be seriously believed that hosts of poor creatures are deprived of the power of hearing without there being many among them whose cases are perfectly curable by scientifically applied remedies? Despair has never yet led to improvement in anything, but a firm and determined acknowledgement of difficulties, and an equally firm and determined attempt to rectify them, has invariably led to at least a measure of gain; and even a modicum of success, where success is so urgently called for, will more than justify me for this departure from well beaten down paths.

That success has already been gained I am myself convinced; and I can point with pride to the fact that for some months my ear patients at the hospital have been treated upon the principles here laid down, and that in every way improved results have followed, so much so that the attendance of patients has within this short period very materially increased, and this in spite of the fact that during this period less medicine has been given than heretofore. But while thus convinced in my own mind of the utility of our procedure, I am still alive to the fact that the judgment to which it will be subjected, and by which it must stand or fall, will be that, not of an enthusiastic introducer, but of a larger number—the larger the better—of calm and critical minds. To them I commend this undertaking, entreating them to become fellow-laborers in a good and useful cause, and one where there is no secrecy to disgust them, no deception to cause dismay, and no quackery to deter or in any way impede research.

BARYTA IOD. FOR SCROFULOUS OPHTHALMIA.—A child, *æt.* 5, had for two years scrofulous ophthalmia under allopathic (local) treatment. There was excessive photophobia and glueing together of the lids in the morning. On general principles, *baryta iodide*, 3 trit., was given, a powder four times a day. Improvement commenced at once and proceeded, so that at the end of two weeks the patient was discharged as cured. Vaseline was used locally to prevent adhesion of the lids, but no other remedy was needed than the *baryta*.—George M. Ockford, M.D., in the *N. A. Journal of Homæopathy*, November, 1892.

ORATION, BY BERNARD S. ARNULPHY, A.M., M.D.,

(Professor of Theory and Practice of Medicine at Hahnemann Medical College of Chicago,
on the occasion of the Memorial Services held in honor of the lamented
Charles Elmer Laning).

WE are met to-night to do honor to a hallowed memory, and as we stand here with sorrowful hearts and dimmed eyes, mourning our departed friend, we feel hanging over our bowed heads the shadow of a great mystery,—the mystery of death.

But death, which our noble calling teaches us to avert and combat, whose very name sends a thrill through the flesh of men, death is not the angel of destruction such as a pallid imagination would depict to itself. Death is an angel of mercy; a great soother and a great reformer. Death is a divine instrument of progress in the weary march of humanity along the path of eternity; an instrument without which the magnificent expanse of creation, instead of the throbbing reality that it is, would sink into a meaningless blank.

A few months ago our friend's genial presence was the soul of our meetings; the hearty shake of his hand imparted the warmth of his heart to the many hands that grasped his, while the quick sallies of his wit, the glow of his honest, searching eye, seemed to betoken a robust health and a nervous battery charged with inexhaustible energy.

Seldom has nature devised a more remarkable organism than that bestowed upon Laning by her bountiful hands.

The sturdy and elastic qualities of his athletic frame, coupled with the keen, penetrating turn of his vigorous, pugnacious mind, might well appear as a splendid achievement of bodily and mental architecture, as a masterful alliance of brain and brawn well befitting a gladiator fighting for a noble cause in the field of advanced thought.

And as we beheld that frame, full of conscious strength; and as we beheld the accumulating tokens of his relentless work, whether in his private practice, whose exacting demands were rapidly increasing, or at the "old Hahnemann," where his original teaching electrified the students, or in the silence of his studio wherefrom flashed, from time to time, short, crisp articles, pregnant with deep insight and mature experience, as we beheld him moving about in

his alert way, bearing his burden with a light heart and a smiling countenance, we had come to look upon his unique performance with a blended feeling of confidence and pride.

Lo and behold! In the twinkling of an eye that mighty frame is shattered, and the beacon-light that shone from it has faded away.

It is not for me to expatiate on the many qualities of mind and heart, some of them admirable, that endeared him to his friends, and even to many who never approached him nearer than the outskirts of mere acquaintance.

There are those among us who can testify to the manliness of his character, to the utter freedom from affectation, and to the sincere cordiality which marked his intercourse with his fellow-men. No afterthought or double meaning ever marred the straightforwardness of his manner; there was no mistaking the expression of his pleasure or displeasure.

He was generous to a fault. There are those who could recount his many deeds of charity,—not that kind of artificial charity so often, as it were, engrafted upon a selfish soil by the agency of some denominational faith. His charity, simple, unostentatious, impulsive, sprang from his innermost heart, as the spring from the rock, the genuine outpour of an abiding love for his fellow-man.

Disguised beneath certain abruptness of approach and bluntness of speech, lay the ever-ready thrill of sympathy, the ever-outstretched hand of help.

Like many other men whose lofty range of vision has enabled them to perch upon the high summits of human intelligence, Laning, carried away by his love of independence, rejected the shackles of dogmatic religion.

It is doubtful whether he ever gave much thought to philosophy, to first principles, to the nature of things, to the meaning of the vast universe around us. He neither pondered over the past nor troubled himself about the future. He lived intently in the present.

Laning was essentially a man of action. His morals were not in words, but in concrete facts. Not in "mouthfuls of spoken wind," but in good impulses crystallized into facts. He did not preach about charity, but practiced it in a way to put many a preacher to shame.

His upright and earnest nature revolted against any exhibition of falsehood. A mean trait of character was hateful to him on the same ground as a careless diagnosis. It grated upon his native

honesty. As a result of his intense, centrifugal nature he threw the whole wealth of his reflective powers on the outside of self, as it were, so that there was little opportunity for him to indulge in the introspective study of the workings of consciousness in the abstract.

No wonder therefore that notwithstanding the height and breadth of his analytical genius as applied to the limited field of medical inquiry, the question of the origin and ultimate destiny of the human soul remained for him not only a sealed book, but a problem devoid of interest.

That our brother, though himself a torch-bearer, lacked a guiding light born from within, or bestowed by a friendly hand from without, is only too apparent from the heart-rending spectacle of the speedy wreck of his life and his work. And from this wreck we may derive a great lesson.

Some persons are known only by their not being somebody else. Laning's entity could not be mistaken. His was a personality in the full-orbed meaning of the word. He was a power.

Incomplete and fragmentary though it be, the work that survives him undeniably reveals a creative genius, not the dreary still-birth of a mind of hearsays.

It appears as the self-raised product of some fertile soil, in the bosom of which the seeds of previous toil and experience had been deposited in ante-natal times shrouded in the mist of the past.

In the course of his checkered and romantic career, we know that he barely missed becoming a professional athlete. Tamed down by a most opportune disease, however, a sudden turn in the path of his life led him to the study of medicine, and his new avocation came upon him as a revelation from another world.

It was to his latent faculties as a spark to gunpowder, as flint to steel, as the touch of vitality to matter, and as in a flash all the infinite train of folded possibilities that lay dormant in his soul, sprang into being.

Then he began to dig and delve in the recesses of his consciousness at the long lost treasure, and if the ruthless hand of death had not prematurely checkmated his ambition, judging from the fragments of his work and the trend of his thought, he would have handed over to us a revised *materia medica* teeming with life replete with unforeseen applications, not a single symptom of which would have been devoid of meaning.

This great work of winnowing away the accumulated and useless chaff of our *materia medica*, preserving only the living seed; this

great work of turning that Sahara of dry and inchoate notions into a verdant oasis, pregnant with far-reaching and scientifically-deducted clinical indications; this homeric work which might have been, for our school, the crowning event of the dying century, he had to leave behind.

The magnitude of the task, and the vast scope of its beneficent results if accomplished, warrant the immensity of our regrets.

Where shall we find in our ranks the man to assume this weighty inheritance? Where is the Ajax who dare put on the arms of Achilles? Laning's collapse, in the midst of his brilliant career, can only be compared to a shipwreck. And it behooves us to halt awhile, and ponder over the philosophy it implies.

Laning lacked three essential things: Spiritual faith, mental discipline, and a true friend.

A spiritual faith might have lifted his intellect beyond the centrifugal influence of his physical nature, disclosing to his inner vision new realms of light and hopefulness. Mental discipline would have enabled him to give better and more precise expression to the promptings of his genius, that is, to mould his thought into more useful and enduring forms. No real brain-worker can hope to accomplish anything great without the lever of mental discipline. Look at the great thinkers of the earth—Bacon, Descartes, Kant, Newton, Hahnemann—they all had strict habits of mental work; and it is doubtful whether they could have accomplished their work had it been otherwise.

Pythagoras, who was perhaps the brainiest man of antiquity, lays especial stress on the necessity of mental discipline; also, of dispensing to the mind due recreation and proper rest to body. The rules of thought and conduct he gives his disciples in his *Aurea Carmina*, I consider as the loftiest monument of philosophy. Would that Laning had been a disciple of Pythagoras!

But, what Laning lacked most, was a friend. Of course he had hosts of friends. Still, he was not vouchsafed that bosom friend whose superior nature melts the ice around your heart; whose elevating influence raises you above yourself, and moulds your habits of life and thought with a gentle, unfelt, but far-reaching authority.

Such friends are rare. When we find one on our life-path, we ought never to turn away from him, for a true and elevating friendship is a gift from on high.

Laning's impetuous, generous, independent nature ill brooked ad-

monition and tutelage; still, of all men, he most needed guidance and restraint.

He, who was so kind to all who approached him, was most unkind to himself. He must have thought that his capital of energy and endurance was inexhaustible; so, he went on, making large draughts upon it, until he fell prostrate on his death-bed.

Personally, I cannot claim to have had a very extensive intercourse with our departed friend. We had an office in common for some months, and though we frequently had occasion to broach medical subjects in conversation, I never gained much insight into his real self until about a year ago.

At that time I happened to be called in consultation with him on an obscure case out in the country. We rode on the cars together, both ways; we slept part of the night together; the better part, however, the examination of the patient once over, we spent walking in the garden around the route, according to his paripatetic and late-hour habits.

It was a clear, crisp, early spring night, and from that never-to-be-forgotten night dates my real acquaintance with Laning. We talked and walked, walked and talked, a hundred times retracing our steps, unconscious of time and fatigue, and whether our minds had been mysteriously brought into communion, or perhaps under the magic spell of that restful yet penetrating atmosphere around us, alive with vernal breaths and softly radiant with the distant twinkling of the stars, we allowed our souls to flow freely into one another.

I might have lived a century in the same street or in the same house with him, and never, perhaps, been afforded such a glimpse of his real nature.

In the course of our rambling talk I stumbled upon tender spots in his soul which I would never have suspected, and which increased the high regard I had for him. But out of the many topics we freely discussed, two stand out prominently in my memory to this day: *autopsy* and *cremation*, and on both questions he was equally enthusiastic. Our conclusion was that every dead body ought to be examined into, then cremated; that each body buried without autopsy was a theft perpetrated upon pathology as well as a menace thrust upon the living.

And now, Laning, we bid you farewell, but we feel and know that you are not lost to us entirely nor we to you. Your presence shall live in our hearts. There, steeped in our purest blood, nursed

in warm sympathy, watered by the dew of lasting regrets, fragrant with the aroma of what was best and manliest and truest in your character, we will grow those sweet flowers of memory which alone are strewn over the resting-place of the elect.

Your inspiration shall live in our minds. It will be an incentive to higher endeavor in the work before us; an encouragement to more earnest efforts while contriving to follow in the wake of your researches.

You have repeatedly shown the students of the "Old Hahnemann" of Chicago how futile it is to enter upon the field of scientific medicine without having previously mastered that still physiology called anatomy, that living anatomy called physiology, and that natural history of disease called pathology.

The medical tripod have you called it? We shall keep in mind that no one perhaps in our school has more clearly and pointedly demonstrated the dangerous fallacy to prescribe for the so-called totality of the symptoms without a working diagnosis in any given case, since the true totality of the symptoms can only be found by the agency of thorough and painstaking diagnosis.

Pausing in awe and reverence on the brink of the precipice which separates life from death, looking into the mist of the beyond from the furthest promontory of this external world, we call out to you, brother, who have found peace in the revelation of the true light beyond the phenomenal appearances, and mayhap you hear our voice; mayhap you feel our yearnings; mayhap you stretch your hand toward our outstretched hand.

For we feel you are living yet, and know that you shall live evermore. For we feel that the accumulated experience and knowledge, that the energy and ambition, and the thirst for light and justice which made the intrinsic worth of your ego cannot be destroyed. For we feel that the thread of life that eternity has woven cannot be severed by time. For it appears to us that *consciousness*, the magic mirror which reveals man to himself and opens to his vision the gates of the infinite, is not—cannot be—the work of a day, of the brief span of a lifetime.

It must be the product of a slow evolution through countless ages and numberless transformations, the result of an ascending process of individualization which, as an irresistible tidal wave, sweeps through the universe, from the latent vital principle contained in the mineral to the plant, from the plant to the animal, from the animal to man, from man to higher forms of life.

We feel that consciousness cannot evaporate into nothingness. Having an eternity at its roots, it must have immortality in the chalice of its flower.

If all that there ever was of Laning were truly dead and gone, life indeed would be a mockery and nature a lie and a curse.

We do not see that it is out of place for us to let drop over the grave of a man like this a few seeds of hope in the guise of philosophical tenets.

We conceive that spirit and matter emanate alike from the substance of God; that matter is only the wilful limitation of the deity; that the divine substance is continually individualizing itself, from the lowest plane of nature to the highest, striving from utter latency to brightest consciousness. For if divinity could not materialize itself into humanity, it were as if it were not. Thus is the immense cycle of life accomplished.

And perhaps, brother, you have by this time, learned to expand your sense of human brotherhood into loftier and broader love for the floating legions of innumerable humanities whose lots are cast upon the sister earths which the Great Sower has scattered through the immensity of space.

For those distant humanities are linked with our ultimate destinies and they all die and are born again, they all suffer and struggle onwards in search of higher pursuits and happier shores.

On those distant worlds as well as on our own earth there are throbbing hearts to soothe, bitter tears to dry, weary limbs to support, tortures of mind and body to heal, failing hopes to revive.

But wherever the lines of your future destiny be cast, brother, we know you shall go on accomplishing your mission of mercy with unfaltering courage and undying energy.

We know that wherever you may be you shall be found a power making for light and truth and happiness against hypocrisy and darkness.

Speed on your way, brother; the path is all before you. One by one we shall follow.

Go forward, brother, toiling on, diving deeper and deeper into the secrets of the universal riddle, all the while gathering strength and light and beauty, through the forms of life, death and rebirth, go forward, until having accomplished your task, and attained the "peace that passeth all understanding" which can only mean self-acquired omniscience, you rest for evermore in the bosom of the Father, your God.

FISSURE OF THE ANUS.

BY T. L. ADAMS, M.D., PHILADELPHIA.

(Read before the Chester, Delaware and Montgomery Counties Homœopathic Medical Society.)

IN the entire range of rectal surgery there is probably no one disease, though in the majority of cases of very limited extent, which is productive of more severe suffering and in consequence general physical disturbance to the patient than fissure. To intelligently account for the remarkable train of symptoms exhibited in this affection it is necessary that we should understand the peculiar anatomical features of the anal orifice. To no part of the alimentary canal is there a more liberal distribution of both motor and sensory nerves than at the verge of the anus. Hilton has pointed out the fact that these nerves, principally branches of the pudic, descend behind the internal sphincter emerged between the muscles at the white line of Hilton to be distributed in innumerable filaments upon the superficial surface of the external sphincter muscle. Through the exposure of these sensory nerve filaments, by the ulcerated surface, impressions are conveyed to that part of the spinal cord from which the pudic lumbar and sciatic nerves spring, thus giving rise to the distressing reflex symptoms of pain in the back, legs and genito-urinary organs; and by the same reflex action the nerves supplying the external sphincter are affected, causing spasmodic action of that muscle.

Fissure may be either the result of a specific infection or a traumatism, more frequently the latter. During the passage of a large fæcal mass a slight tear is made in the delicate mucous membrane at the verge of the anus. This tear, however slight, will expose one or more of the nerve filaments and as a result, by reflex action we have produced alternate contraction and relaxation of the sphincter, which will continue to increase in frequency and intensity until the patient's life is rendered almost unbearable by the intense suffering. While the pain at first is paroxysmal and follows the act of defecation, we find as the disease progresses and the irritability of the parts are correspondingly increased, an attack is liable to occur at any time which will completely incapacitate the patient mentally and physically. As a result of the almost constant distress the patient is apt

to look for something palliative and will resort to narcotics of various kinds which in turn produce severe constitutional symptoms; loss of appetite, sallow face, careworn countenance, general languor and debility. The constipation is greatly increased, the stools becoming tape-like and flattened, this being due to the incomplete relaxation of the sphincter.

In a patient presenting such an array of symptoms we can with almost absolute certainty make an accurate diagnosis, even without further examination, as we find no other rectal disease producing such characteristic distress. Upon more careful examination, however, with the patient placed upon the left side, the knees well flexed upon the abdomen and a good south light we will be able to fully satisfy ourselves of the true condition. It is generally claimed that in the majority of cases the first thing to which our attention will be drawn is a small red prominence situated at the verge of the anus, which is termed the sentinel pile.

In recent cases I think this condition is rarely, if ever present, and that we are more likely to find a papillary growth situated either at the upper margin of the fissure and falling down and resting upon the ulcerated surfaces or on the opposite side of the anus and projecting into the fissure, being a source of constant irritation to the already inflamed parts. A gentle traction at the verge of the anus together with the separation of the anal folds will in most cases bring into view the lower two-thirds, if not the entire ulcer, showing a reddish-gray or purple streak of greater or less width and so sensitive is the surface involved that even this slight manipulation will often subject the patient to the most severe suffering.

Unless from other symptoms malignant disease is suspected such an examination is amply sufficient to determine the true condition and the introduction of the finger or speculum into the anus without having the patient completely anæsthetized or the use of a local anæsthetic is positively brutal, and one guilty of such procedure should be severely censured. Being satisfied that we have a non-malignant ulcer to deal with, we can with the greatest amount of certainty give a favorable prognosis, also promising no after effect, providing the proper treatment is adopted. The application of stimulants to the fissured tract for the purpose of inducing granulations, even if the case be a very recent one, will be met with poor success, as the great irritability of the sphincter, its almost constant involuntary contraction and relaxation, will break down the healthy granulations as rapidly as they may form and sooner or later more

heroic measures will have to be resorted to. I say heroic measures and yet desire to take exception to the very heroic measures resorted to generally in the either complete division or over distension by stretching of the sphincter muscle.

When we consider the character of the tissue surrounding the termination of the bowel, that it is largely made up of loose connective areolar tissue through which the plexus of valveless hæmorrhoidal veins ramify, we will understand that the sphincter when naturally performing its functions will act as a floor or support to the parts and to absolutely or even partially permanently destroy this function will be followed by conditions most unsatisfactory both to patient and physician. As a result of an improper division of the muscle we will find the anal orifice assuming the most varied shapes; triangular, elliptical, semicircular, its power either entirely or partially destroyed; so that while incontinence as to the ability to retain fecal matter may not exist (this being due to the action of the internal sphincter, which has not been sacrificed in the operation) there will be protrusion of mucous membrane, not exactly a prolapsus nor yet a true hæmorrhoidal condition, but rather from want of support there appears to be a redundancy of healthy tissue which will completely fill up the irregular opening. This protrusion of mucous tissue will gradually change in character, becoming cutaneous, and as a result, we find the margin of the anus completely surrounded by these cutaneous tags which upon the slightest provocation will become inflamed; this inflammation resulting in suppuration with a great liability for the pus to burrow into the surrounding connective tissue and before we are aware of the fact we have a fistula to deal with, which, with the complications mentioned, means a most troublesome case to manage.

Almost the same conditions will follow the over-distension of the sphincter, with the exception that instead of having the irregular margin the anus will appear like the end of an open pouch, with the mucous tissue filling it partially or entirely and the same train of symptoms following as before enumerated. While there are diseases of the rectum which in their treatment may require division of the sphincter, the operation, though considered so simple by the profession generally, should be performed with the greatest amount of care if we do not desire to permanently destroy the utility of the muscle. As to its over-distension by stretching, that is, carrying the operation so far as to lacerate the muscular fibres, it is not admissible under any circumstances, the results following its practice

being often far more serious than any condition for which it might be used as a curative measure. If we are able to destroy the excessive irritability of the muscle it will be surprising to note the rapidity of the healing process in the ulcer and that we are able to destroy this irritability without in the least permanently affecting the utility of the muscle is beyond question.

We are well aware of the fact that in intractable cases of neuralgia the most satisfactory results have followed the treatment of producing anæsthesia of the parts by the process of nerve stretching. By applying this same treatment to the nerve filaments, not only involved in the fissured tract but to the entire circumference of the termination of the bowel, we will have the same happy results, *i.e.*, the complete destruction of the irritability of the muscle by anæsthesia without in the least impairing its function, and as a consequence, the ulcer thereafter being but slightly disturbed will rapidly granulate and heal. To accomplish this result it is necessary that we should have the patient thoroughly anæsthetized, and as the operation can be performed in a few moments, the best anæsthetic to be employed is the nitrous oxide gas. The patient having been placed on the left side in the same position as for an examination, the operator, after having thoroughly anointed the index finger of both hands, should insert them deeply into the anus back to back and make the traction laterally midway between the transverse and antero-posterior diameters, as in this direction he will find the most room, escaping the pudic bone and coccyx antero posteriorly and the tuberosities of the ischia transversely. The traction should first be made by a quick, jerky motion, being careful not to use too much force. This manipulation will tend to temporarily overcome the rigidity of the muscle. This point being gained the traction should be continued by a steady and gradual separation of the fingers in the same direction and carried to the point at which we feel the resiliency of the muscle commencing to give, when it should be immediately suspended. As we have now accomplished our object by subjecting the nerve filaments to this stretching process any further manipulation will be unnecessary. After the patient has regained consciousness there may be a slight smarting or burning sensation complained of, but it will be of short duration and the introduction of a one gr. coc. sup. will suffice to make the parts perfectly comfortable. There are rarely, if ever, any unpleasant symptoms following save possibly a slight soreness or lameness of the parts, which will not be sufficiently noticeable to take the patients off their feet,

and by the application of hot fomentations applied once or twice for five or ten minutes at a time, will entirely subside in the course of forty-eight hours. The after-treatment will consist principally in using antiseptic measures and possibly the application of a slightly stimulating lotion should the ulcerated surface seem slow to granulate.

A fissure under this treatment will be thoroughly healed in from five to eight days; and during the healing process the patient will be kept perfectly comfortable. A few cases are here appended, showing the results obtained from this treatment:

1. E. B. H., age 27, a travelling lumber salesman, had suffered for five months with a fissure situated posteriorly. His bowels were constipated, having but two or three tape-like stools a week, and the days on which he did have an evacuation he was obliged to remain in a recumbent position for several hours afterward. He was operated upon, and in one week the ulcer (which was quite an extensive one) was entirely healed, without any further treatment save antiseptic measures.

2. H. W., age 30, married woman, no children, had suffered for three years with fissure situated anteriorly. The pain had not been particularly severe until within the last year, when it gradually increased in severity after each act of defecation, and finally became almost constant. Upon examination I found a fistulous tract commencing at the lower edge of the fissure, with an external opening in the perinæum about three-quarters of an inch from the anus. The manipulation of the sphincter, together with an opening up of the fistulous tract, effected a speedy cure of both conditions.

3. A. K. S., age 31, contracting painter, had been subject to constipation for years in consequence of his exposure to the lead used in his business. About one month before calling upon me he had a severe attack, and in expelling a very large stool, the accumulation of several days, sustained a tear of the mucous membrane, extending from the verge of the anus to the upper margin of the internal muscle. He complained of the most excruciating pain during and after the act of defecation, but in the interval, between movements, had little or no inconvenience. He was operated upon in the usual manner, and directed to call at the office the next day. I did not see him again for two weeks, when he called and informed me that he had not the slightest pain since the operation, and for that reason had not thought it necessary to see me sooner. An examination revealed no trace of the fissured tract.

4. M. W. C., age 48, married woman, mother of four children, youngest eight years, since which time she has suffered with hæmorrhoids, and which in the year and a half before applying for treatment had become complicated by one of the most extensive fissures I have ever seen (more than one-third of the entire circumference of

the anus was involved), and extending to above the internal muscle. The patient was such a physical wreck from her extreme suffering that she was unable to get to my office, and I therefore operated at her home. The usual manipulation of the muscle, which was greatly hypertrophied, was followed by entire and almost immediate relief, the ulcerated surface granulating nicely, and was completely healed in about two weeks, after which time she came to my office and was treated for the hæmorrhoids.

5. C. S., age 27, real estate agent, had become constipated from the sedentary life he led, being confined every day in his office. About two months before applying for treatment, during the expulsion of a large fæcal mass, he became the victim of a traumatic fissure. He was discharged in five days after the operation, the tract being perfectly healed.

6. W. K. N., age 39, manufacturer, a very nervous excitable man, had suffered for about one year from a fissure situated anteriorly. The examination revealed a peculiar condition in that while the fissure in itself was very small, the irritability of the parts was something terrific, the muscles being greatly hypertrophied and so tightly contracted that until a local anæsthetic was employed it was impossible to obtain a view of the parts within the anus at all, in fact the muscle was so tightly contracted that the opening seemed entirely occluded and I think it would have been impossible to pass so small an article as a lead pencil into the bowel. I feared in this case that I would be obliged to divide the muscle, but the patient being greatly averse to the use of the knife, I decided to do the usual manipulation. The results obtained were all that could be desired, the ulcer in the course of a week was entirely healed, the muscle had regained its normal tone and after the removal of a papillary growth which was situated just within the anus and on the opposite side to that occupied by the fissure the patient was discharged cured.

7. A. W. L., age 33, married woman, no children, applied for treatment of a fissure of some six months' standing which was complicated with hæmorrhoids. An examination revealed the presence of a large uterine fibroid, which had so encroached upon the anterior wall of the rectum as to almost close the bowel. By the use of a local anæsthetic was enabled to slightly manipulate the muscle, which was followed by a cure of the fissure. She was then advised to consult a gynæcologist for the treatment of her uterine trouble, the hæmorrhoids being entirely dependent upon that condition. It is more than likely however that she will always be a sufferer.

Having given in these few cases a variety of forms this disease may assume, from the simple fissure to one complicated by other troubles, it would appear that in nearly all cases we may hope and expect that conservative measures employed in their treatment will nearly if not always prove curative.

DIFFERENTIAL DIAGNOSIS OF PSEUDO-MEMBRANOUS LARYNGITIS AND
LARYNGEAL DIPHTHERIA, WITH RESULTS OF TREATMENT
BY INTUBATION.

BY H. J. EVANS, M.D., ALTOONA, PA.

As the season is approaching in which laryngeal afflictions are very prevalent I thought it not out of place, at this time, to give a general practitioner's experience in those two dreadful diseases over which medicine seems to have so little influence—pseudo-membranous laryngitis and laryngeal diphtheria.

Text-books are rather confusing in the nomenclature of the two diseases, for instance, we read of membranous croup and true croup, on the other hand we find a description of diphtheritic croup. I think the term croup should be discarded as applied to the name of a disease, as we all know it simply means conditions associated with peculiar sounds and should not be used to express certain physical and histological elements in products of inflammation. In the mind of pathologists the question is an unsettled one as to the identity of pseudo-membranous laryngitis and laryngeal diphtheria, and yet to the physicians, whether he be of the old or new school, it is an important consideration from an hygienic point of view. The writer considers them two distinct diseases each one throwing out a plastic formation yet, histologically considered, the exudation found in pseudo-membranous laryngitis is identical with that found in laryngeal diphtheria, consisting mainly of epithelial cells, a stroma composed of mucus-corpuscles and a network of fibrin with some blood cells and in addition, in the latter disease, we find some vegetable parasites. Pseudo-membranous laryngitis is a local disease ushered in by slight catarrhal symptoms, with some fever, coryza, and hoarseness; these symptoms may continue from twenty-four hours to a few days, when a cough, with a brazen ring shows itself; this cough is paroxysmal, breathing becomes croupal, temperature increases, much thirst, but not much appetite; these symptoms prepare the seat for the reception of that monster foe with which the little patient must wage a desperate warfare, short but usually decisive. You now find established on the mucous membrane a yellowish white plastic exudation varying in thickness, from a mere film to one-eighth of an inch; it is found either lying on the tissues or interstitial. Its primary seat is in the larynx but sometimes first develops in the pharynx

and descends and when you find the marked dyspnoëic tension of the muscles of the neck you will know the exudation has reached the larynx. The inspirations are long drawn, the little chest muscles are exerted to their fullest extent and the respirations are very rapid; cyanotic symptoms set in, face becomes deep red and from that to blue, or even a pale blue; child presents a picture of terror, throws itself from one position to another, limbs become cold and unless relief comes quickly, either from medicine or an operation, death is a welcome visitor to the little warrior who simply strangles to death. There is no tendency for this exudation to invade the nares, œsophagus or other regions, neither do we find it on any abrasions of the body. I have failed to detect any albuminuria during its progress or paralysis following a recovery.

PREDISPOSING CAUSES—Age.—You find the disease more frequent from the first to the seventh years, although I have treated one case of 12 years of age. Season is one of the powerful predisposing causes, especially November, December, January and February, but in this region, it is very prevalent in October and in fact, found at all periods except, perhaps June, July and August.

Duration.—The disease lasts from one day to thirteen, but where the membrane has developed before the physician is called, a few days will close the scene; in referring to my notes I have had cases die in forty-eight hours and one lived for fourteen days. Da Costa says this malady is not contagious as diphtheria is; while Jacobi says it is contagious for he says, in the same family, from a case of croup, other cases of laryngeal croup may originate; within the last year I had under my care a child sixteen months old with acute catarrhal laryngitis, and in three days an older sister six years, was taken with pseudo-membranous laryngitis, and among my notes, I find several other instances of different members of the same household being affected similarly, which has satisfied me that the disease is slightly contagious but not in the degree that diphtheria is contagious.

Diagnosis of Laryngeal Diphtheria.—In this disease, you find a constitutional malady, a specific contagious and infectious disease; it manifests its onset with a prodromic stage of a few days; if the patient is old enough to describe his case he complains of languor, loss of appetite, stiffness of the neck with the glands of this region very sensitive and slightly swollen; the throat presents a red appearance, with headache, temperature rises, yet not much febrile excitement; deglutition is not always painful in the first stage. The submaxillary glands become very much enlarged and the red throat

shows signs of an exudation, a fibro-plastic membrane whose histological construction is similar to the exudation found in pseudo-membranous laryngitis; this membrane soon changes from a whitish-gray to a darker hue due to a mixture of blood-cells and parasites, inflammation is more marked, with a more rapid spreading of the exudation and a preponderance of fibrin, than we find in the former disease. The exudation may extend up into the nares or œsophagus. Jacobi says the descent of the membrane into the larynx is not always found to pass uninterruptedly from the fauces into the larynx; not infrequently isolated patches are found about the epiglottis, but they coalesce and form a continuous membrane. The primary seat of exudation is usually in the pharynx. As the membrane invades the larynx, the same objective symptoms present themselves as observed in the former disease, and as Trousseau forcibly declares that the patient not only dies from suffocative paroxysms as in pseudo-membranous laryngitis, but in addition general poisoning. In laryngeal diphtheria, albuminuria is a concomitant symptom, and cutaneous eruptions are frequently seen, and if the patient survives paralytic symptoms are common sequelæ.

Treatment of Cases by Intubation.—To Dr. Joseph O'Dwyer, of New York, is due the credit for the appliance used to-day in successful intubation of the larynx. The outfit consists of an introducer, obdurator, extractor gag, scale and five tubes; while we admit that intubation falls short, in many respects of curing all cases of these two diseases, yet it has been the means of reducing the high mortality of 90 per cent. down to almost 60 per cent. True it requires a closer observation of the patient while the tube is *in situ*, than does tracheotomy, but it lacks the objection, connected with a more or less bloody operation, and the results are more favorable than you obtain in the latter treatment. The following report is the result of eight cases which I treated by intubation, two of the number having laryngeal diphtheria:

CASE I.—Jessie A., æt. 6, pseudo-membranous laryngitis. Became sick May 1, 1889; tried the indicated remedies for three days, kali bich., iod., brom., spong., etc.; the patient improved none, cyanotic symptoms began to manifest themselves, the exudation was very plainly seen surrounding the epiglottis.

With the assistance of Dr. Morrow, after three unsuccessful attempts, I succeeded in inserting a tube into the larynx; the croupous breathing disappeared almost with the first respiration after insertion, and the cyanotic symptoms passed off in a few moments. The little patient experienced some difficulty in swallowing, and

coughing troubled her, due to the presence of the tube; kept her on semi-solid food and continued kali bich. 3x. May 6th removed the tube with the extractor, left a decided hoarseness which disappeared in ten days. In this case there were no very annoying symptoms following the introduction of the tube, the little patient suffered no inconvenience, did not even desire its removal when necessary.

CASE II.—September 7, 1889, George K., æt. 5 years, had been under old-school treatment for a few days suffering from pseudo-membranous laryngitis, lived in the country; the patient was of a scrofulous diathesis, had frequent attacks of catarrhal laryngitis; with the aid of the father of the child and a neighbor the tube was introduced without much effort; the child coughed a great deal and was very much annoyed from an accumulation of mucus in the tube, but would dislodge it without displacing the tube.

In this case I left the cord attached to the tube as an extra precaution in case of the tube dropping into the bronchii.

The tube was left in position three and a half days. The boy made a complete recovery. I kept this patient on iod. 30.

CASE III.—October 22, 1889, Mabel N., æt. 7, living in an adjoining town, found the membrane developing rapidly, and twenty-four hours from my first visit, the cough becomes decidedly croupous, the child was very anæmic, restless, tossed about the bed in hopes of securing better respirations; after several attempts with the assistance of some ladies of the house, I inserted the tube; the child became quiet, went to sleep shortly, and progressed nicely for three days when she coughed up the tube, still leaving the cough very croupous and the membrane still in view. I reinserted it without difficulty and left it remain for two days longer, keeping the patient on kali bich. 3x during the entire period of treatment.

CASE IV.—October 23, 1889, Mary M., æt. 2 years, patient of Dr. Morrow's, had been sick for three days. The membrane was very thick; child fat, chubby; cyanosis marked; inserted the smallest tube at 1 A.M.; rested well all night; breathing still remained croupous after the insertion of the tube; took nourishment in the morning, and half an hour after it partook of food coughed up the tube. At 9 A.M. tried to re-insert the tube, but failed to do so; stenosis of larynx was very marked. Child died near evening of the same day. In this case the membrane had evidently descended into the bronchii, as the croupous breathing continued after the insertion of the tube.

CASE V.—October 24, 1889, Earl G., æt. 5 years, laryngeal diphtheria. The disease commenced in the nasal passages, profuse epistaxis, glands of the neck all swollen, filling out the depression at the angle of the jaw; the exudation spread very rapidly over the fauces, uvulæ and covering the pharynx, of a very dark hue, dipped into the larynx, then the child became very croupous in breathing. I inserted the tube, but its presence aggravated the cough and a continuous gagging kept up. Then I was obliged to

remove the tube. The little sufferer died October 27th, three days after the membrane showed itself in the throat.

CASE VI.—November 7, 1889, Ethel L., æt. 21 months, child of fair complexion, light hair. Was called November 7th; could discover no exudation; sneezing, pulse rapid, much thirst and very hoarse, with croupy cough. Gave *acon.*; no abatement of symptoms for twenty-four hours. Changed to *spongia.*; croupy cough continued. November 9th detected an exudation above the epiglottis; November 10th inserted the smallest tube, but it did not relieve the condition. Thinking it was too short, I removed it and inserted a larger size, which gave quick relief. Owing to the excess of mucus collecting in it, I removed it in twenty-four hours, leaving the child in the same condition as previous to insertion; reinserted the same tube, but it produced a tormenting ordinary cough, which bell. 30, controlled. Child became very restless, tossed about, face flushed, would cough violently when drinking; these symptoms subsided in a short time, but was followed by marked crepitation on anterior surface of the lungs; fever would increase every evening. November 14th, coughed up the tube, leaving the membrane very distinct and cough, with respiration, very croupous. At the expiration of six hours again inserted the tube with marked relief of the croupous breathing and cough. November 17th, in the act of dislodging the mucus from the tube, she coughed it up. An examination of the larynx showed the membrane to be nearly all gone and the cough not so croupy, but a decided case of bronchitis followed. In this case the remedies had to be frequently changed to meet the distressing symptoms, which I considered accounted for the delay in clearing up the plastic exudation.

The croupy symptoms had all disappeared by November 18th, and the child made a complete recovery from the bronchial complication.

CASE VII.—November 15, 1889, Barbara R., æt. 8 years, brunette, flabby, muscular constitution. Was called in the evening; found a slight deposit on the pharynx, with some cough, not croupy; child had taken cold from dampness; prescribed *iod*, continued it for twelve hours, when the cough became croupy; prescribed *kali bich.*, but with no improvement. Intubation relieved the breathing, immediately croupous cough disappeared, but she complained of the tube hurting her; this annoyance soon passed off. She coughed up the tube after a determined effort on her part. The mother refused to have it re-inserted and the patient died November 18, 1889.

CASE VIII.—Chas. H., æt. 7, dark hair and eyes. December 16, 1890, discovered a small yellow deposit on right tonsil; tongue coated thick, creamy; patient was bright and cheerful, ate well, slept well, limbs ached, much thirst; prescribed *merc. bin. 3x*. The next day the patch on the tonsil had disappeared, aching subsided. December 19, 1890, was summoned hastily; found his temperature 100° F., pulse 110; headache; glands of the neck enlarged and both tonsils covered with an exudation; and a short cough. I

prescribed iod., but this did not remove the cough, and the patient grew worse; breathing became labored and cough croupous; appetite failing and the membrane rapidly spreading. December 24, 1890, after repeated efforts, succeeded in inserting a tube. Immediately the condition of the patient improved. The tube was coughed out of the larynx twice; and while inserting the tube was coughed up and passed down into the œsophagus; it was passed per rectum the next day. The duration of intubation was four days, and the patient made a very nice recovery.

O. Dwyer's statistics, collected up to 1887, gives 806 intubations, with 221 recoveries, or 27.4 per cent. This includes many operations with imperfect tubes when first introduced.

THE JAPANESE FIRE-BOX AS AN INSTRUMENT FOR THE APPLICATION OF DRY HEAT.

BY CLARENCE BARTLETT, M.D., PHILADELPHIA, PA.

THE great benefit derived from the application of dry heat in certain painful and inflammatory affections is well known. The Japanese fire-box as a means of applying this heat has not received the professional attention it merits. I have used this little instrument for some time past with such satisfaction as to lead me to present this communication.

The Japanese fire-box is mostly used by ladies as a means of warming the hands when out shopping. It is carried in the muff. It consists of a small tin box with sliding lid, and covered with felt paper or velvet. Accompanying the box is the fuel, which consists of a piece of some slow-burning substance, about four inches in length. The boxes are sufficiently large to hold from two to four of these, although but one is ordinarily used at a time. They will burn from three to four hours without any attention. The degree of heat obtained from them is about the limit of the patient's endurance. The great advantage presented by the instrument in medicine is its light weight and the readiness with which it may be prepared for use. In these respects it is far ahead of the rubber hot-water bags so generally used. In cases of abdominal troubles in which local application of heat is indicated, it may be slipped under the vest, or beneath the waist, while the patient goes about. In cases of facial neuralgia the patient may lie with his face against it, or even go

about the house with it kept in place by a few turns of bandage. At present I am treating with good results a case of chronic myalgia of six months' duration by the application of the fire-box twice daily. Each time the instrument is kept on until the "punk" burns out.

The apparatus is perfectly safe; there is absolutely no danger of setting fire to clothing or bedding. It is likewise very cheap. The punk comes in packages of ten each, which retail at ten cents per package, or three packages for a quarter.

I believe that the profession will derive as much satisfaction from the employment of this little adjuvant to medical treatment as I have.

A MODIFICATION OF SIMS'S SPECULUM.

BY F. B. SCHMUCKER, M.D., READING, PA.

THIS simple device consists of a weight attachment, the upper ends of which are so bent as to fit easily in two perforations near the end of the blades of Sims's speculum. In operations on the uterus, many gynecologists now prefer to use Sims's speculum with the patients in the dorsal or lithotomy position. To hold the old-style speculum in place requires the aid of an assistant, whose position is necessarily

awkward, and whose hands often interfere with the freedom of the operator. This modification of the speculum obviates the necessity of an assistant, and is found to answer a most admirable purpose. The perforations are made in both blades, so that either blade can be used by transferring the weight to the other, the ends of the wires dropping easily into the perforations. With the patient in proper position on the operating-table, the speculum never slips, but makes steady traction in the proper direction. To those who have tried it, this instrument has given most gratifying satisfaction.

EDITORIAL.

MEDICAL EXAMINERS' BILLS IN PENNSYLVANIA.

ACTUATED by the desire to *control* medical licensure in Pennsylvania for the avowed purpose of destroying sects in medicine, the allopathic physicians have had introduced into the Legislature of Pennsylvania a bill which provides for the establishment of a single board of nine medical examiners, to be appointed by the Governor. The persons selected are to "be graduates of some legally chartered college having the power to confer medical degrees, with ten years' active practice, no two of whom shall be residents of the same county, and none shall be a member of the faculty or staff of any medical school or university." . . . "The applicants shall be examined in anatomy, physiology, chemistry, pathology, hygiene, toxicology, differential diagnosis, surgery and obstetrics." This bill is certainly not satisfactory to those prompted solely by a desire to elevate the position of medicine in the State, and to protect the public from irresponsible practitioners. Inordinate covetousness for control of all who may want to practice in Pennsylvania has led to striking out examinations in all branches which bear directly upon the welfare and safety of the public, in the hope that by so doing the members of the Legislature may be misled, and that the opponent schools be soothed into offering no opposition. The bill really offers no protection to the public. So long as a candidate is a good anatomist, differential diagnostician, etc., it is a matter of utter indifference to its framers how bungling and incompetent a practitioner he may be. *Materia medica* and therapeutics are as nothing to them. And yet the public will be perverse. It may flatter them to know just what is the matter when they are ailing; but they will surely demand, above all things, that their physicians shall know how to treat and relieve them when they are sick. "The good of the public" did not conceive and bring forth this bill; it was lust for the control of all schools of medicines by the dominant or allopathic profession, and the desire to exterminate hated rivals. Argument will be brought forward that this bill will entail no special hardship on the minority schools of medicine in the State, for the Governor *may* appoint, if he sees fit, a board composed entirely of homœopathic physicians; but the makers of this choice bit of legislative literature cherish no such idea, for in their own hearts they know the logic of the situation to be that their school—the allopathic—will be sure to acquire, sooner or

later, *majority* control, even if, in the single board, the appointments are left discretionary with the Governor. The representatives of one school will always and imperatively be in the majority in a single board of examiners.

A plea will be put forward that a single board of examiners is the only method by which a uniform standard of acquirements can be obtained. The absurdity of this proposition is apparent, especially with all the avenues that are opened for favoritism or fraud in the single board.

The allopathic leaders will assert that they are entitled to a majority representation upon a single board of examiners because their schools hold numerically the largest membership of educated and qualified practitioners. In answer to this :

The law recognizes three distinct schools and systems of medicine, each of which has acquired a similar legal status ; all exercise the same legal rights and privileges without regard to the number of members thereof. These civil rights and privileges are not increased or diminished in proportion to the ratio of membership, all the schools and systems being regarded, in the eye of the law, as equal and similar in every respect. The right of medical licensure constitutes a civil privilege ; one, the free exercise of which belongs to the representatives of one school as well as to those of another, whatever the relative numbers of the different schools may be.

The rather exhaustive provision made in the bill to suppress the identity of a candidate to his school amounts to nothing ; every legislator understands its uselessness, and they will also recognize the unfitness of compelling allopathic physicians to violate their conscience and their code of ethics, which compels them not to recognize any but their *own* graduates as physicians. With a single medical examiners' board, no self-styled "regular" physician in good standing could serve as a member of such a board and remain a consistent and honorable gentleman. He must either violate his "dark-age" code or prove false to the trust reposed in him by the State.

The homœopathic profession, in meeting this question of medical legislation, recognized that "medical examiners" would not reach the root of the trouble desired to be removed ; but not wishing to place any hindrance to a possible improvement, it was decided to accept the transfer of the right to practice medicine from the diploma to the license ; and in preparing their bill they sought, first, *fair play*, by assuring exact and equal justice for all schools of medicine ; sec-

ondly, freedom from majority rule in the exercise of personal opinion in medical matters; third, the right to examine and license its own candidates by each of the schools. The bill, as completed, will be found on page 27 of the *News and Advertiser* of this issue. A careful reading will show provision for the highest, practical, standard of qualification; with a method for assuring absolute uniformity in the examination of all branches where it is possible; and that each school is given entire jurisdiction over its own students by having granted a separate and distinct board. This bill is practically the same as is in favorable operation at present in the State of New York, where it is endorsed and heartily supported by all schools. It is a fair bill. It treats all schools alike, and will obtain the purpose desired by those who are honestly striving to elevate the standard of medicine and seeking the advancement of public interests only. It will have one fatal effect, however, which will bring out all the latent opposition of allopathy and delay once again medical advance in Pennsylvania. It will destroy forever the possibility of any one school having a controlling power in medicine in Pennsylvania.

The allopathic school has been and is the enemy of medical reform, and the present session of the Legislature will adjourn *sine die* without any improvement in the medical situation unless the old school can cure itself of its itch to control the licensing of homœopathic physicians. Members of the Legislature are not blinded by medical prejudices and can readily see through a grindstone when there is a hole in it. If the allopathic physicians can get over their longing for control and withdraw their opposition to the homœopathic school exercising exclusive and final jurisdiction of its own students, and be content with the same right with their own, a board for each is in easy reach; for any point contained in the three-board bill not sufficiently explicit can easily be provided for by suitable amendments. It is for the allopathic school to say whether or not Pennsylvania shall have medical reform this year. A single board cannot and will not be accepted by the minority school.

ERRATA.

In article on "The Importance of Suspecting a Possible Relation of Cause and Effect between Chronic Diffuse Nephritis and Unyielding Affections of Obscure Pathology," by Wm. A. Haman, M.D., appearing in the January, 1893, number, pages 16 to 23, where the word "grammes" appears, read "grains."

GLEANINGS.

GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D., AND FRANK H. PRITCHARD, M.D.

CARDIAC BRUITS AUDIBLE AT A DISTANCE FROM THE CHEST.—Dr. Alexander M. M'Aldowie cites three cases: 1. In single man, aged 37, admitted in state of delirium and high fever. History: good health until two weeks previous; lung-fever; slight cough, without expectoration; great dyspnoea. A loud systolic murmur was heard, with greatest intensity over aortic area and over anterior part of right lung. Bruit transmitted up carotids but not round to axillæ; at apex normal sounds. Bruit was bellows-like, audible one yard from chest. Patient died in three days. Post-mortem showed healthy valves excepting aortic, two cusps of which were thickened; valve was competent; the lining membrane of aorta was deep red in color with numerous patches of atheromatous and calcareous degeneration. Extending diagonally upwards from the upper part of left posterior sinus of Valsalva was a recent rupture of the inner and middle coats, three-quarters of an inch long, with jagged, irregular edges, projecting into interior of vessel. The bruit was attributed to this lesion. 2. Male, aged 28. History, of good health. He had two attacks of loss of consciousness, lasting an hour; the attacks being attributed to grief. Two months afterwards an attack of bronchitis which left a permanent "cooing" in chest, much dyspnoea, but no other symptoms. On examination, marked epigastric pulsation, marked pulsation in carotids and in all superficial arteries; strong diastolic thrill; a long, rough bruit heard all over chest, maximum intensity at aortic cartilage; murmur occupied place of second sound, the first being heard at apex, normal in character but exaggerated; the murmur was heard plainly ten feet from chest (in quiet room); in carotids murmur was double, systolic portion faint, diastolic loud and rough. Patient left hospital improved. 3. Man, 36 years. While lifting a heavy cask felt something snap in chest; immediate unconsciousness ensued, lasting 24 hours. On recovering his senses he had dyspnoea, and heard a continual "cooing" noise in chest. A loud, harsh, diastolic bruit was heard all over chest, and could be readily distinguished three feet from patient's body. This murmur was due, undoubtedly, to a ruptured aortic segment. In all three cases, it is curious to note, the murmur was due to cardiac overstrain. The clinical significance of these loud transmitted murmurs invariably indicate serious lesion at the aortic orifice, although Osler relates one which vanished occasionally, and was evidently functional. In general, the loudness of the murmur depends to a great measure on the condition of the muscular substance of the heart. A loud systolic murmur shows that the ventricle is acting forcibly, and that it is well nourished. A loud diastolic murmur indicates a more serious condition, for it requires in addition to a strong ventricular contraction, a very free regurgitation, and therefore an extreme variation in the blood-pressure during the phases of the cardiac cycle.—*Edinburgh Medical Journal*, January, 1893.

THE TREATMENT OF RHEUMATOID ARTHRITIS.—Pepper recommends that cases of this disease be not treated as cases of rheumatism with salicylates, the iodides and the like, but by such agents as relieve profound depression of the nervous system, as cod liver oil, arsenic and iron. Massage, appropriate passive movement of the joints is an especially important measure. Without this it is absolutely certain that the joints will become distorted, and the patient will become more and more helpless. A mild galvanic current free from interruptions should also be passed through the nape of the neck, through the affected nerve tracks and the dorsal region.—*International Clinics* Second series, vol. iii.

DIETARY IN CHRONIC NEPHRITIS.—In a discussion on the most suitable dietary in chronic nephritis, Dujardin-Beaumetz said it was not the albuminuria but the accumulation of toxic substances in the blood that required attention. The indication

is, therefore, to assist the elimination of these poisons, and to prescribe such a regimen as will tend most to limit their production. To this end, severe mental and physical exertion should be avoided. As toxines develop in meat three days after the death of the animal, he thought meats not absolutely fresh should be avoided; also for the same reason, fish, game, oysters and cheese. Milk should form the most important part of the dietary, but it should be sterilized. He never saw the albuminuria increased by the administration of eggs. Meats should be well cooked. Those which contain a considerable amount of gelatine are the most suitable. Among the starches he placed a high value on rice. He thought it also desirable to limit, if possible, the formation of toxic substances in the alimentary canal by the exhibition of such intestinal antiseptics as benzo-naphthol and salol. Dr. G. See advised a dietary somewhat as follows: Milk, one litre; white bread, two hundred and fifty grammes; butter, fifty grammes; sugar, fifty grammes; soup, five hundred grammes; coffee or tea, five hundred grammes; macaroni, one hundred grammes. He thought drugs of little use to patients suffering from albuminuria. With the exception of caffeine and lactose, which sometimes prove very efficacious, diuretics should be avoided.—*International Medical Magazine*, December, 1892.

THE USE OF MENTHOL THROUGH THE STOMACH TUBE.—Dr. A. L. Benedict reports most excellent results in cases of gastric neurosis and atonic dyspepsia from the local use of menthol spray administered through the stomach tube. It is first necessary to wash out the stomach in order to remove from the mucous membrane all mucus and foreign particles which will interfere with the efficacy of the local medication. The patient is directed to take no food within at least four hours of the time of appointment, and the last meal should be a light one. After the water is removed as thoroughly as possible from the stomach by siphonage, the menthol spray is introduced. Any atomizer that will spray an oily solution is sufficient. The solution should be a one to five per cent. solution of menthol in any of the colorless substitutes for the crude officinal liquid petrolatum. The spray is then directed into the funnel, a piece of cardboard being used to prevent a rebound of the vapor from the sides of the funnel; or the funnel may be removed and the tip of the atomizer introduced into the tube. For a minute or two the vapor from the atomizer will meet with some resistance from the small amount of water remaining in the tube, and on auscultation bubbling may be heard in the stomach. The vapor should have an alternate ingress and egress. By pinching the tube close around the tip of the atomizer the stomach may be fully distended, and it should be allowed to contract on its gaseous contents, when the vapor and even drops of water will be expelled with considerable force from the mouth of the tube. The illustrative cases reported by the author, show most remarkable results from the treatment.—*International Medical Magazine*, November, 1892.

CODEINE IN THE TREATMENT OF THE MORPHIA HABIT.—A writer in the *New York Medical Journal* extols the virtues of codeine in the treatment of the morphia habit. He warns his readers, however, not to expect that the use of this drug will lead to the abandonment of morphia without some help from the patient also. It simply makes the effort easy. When pain, for which the morphia had previously been taken, comes on, codeine is given, the dose varying according to the extent of the previous use of morphia.—*N. Y. Medical Journal*, January 7, 1893.

IS EVOLUTION TRYING TO DO WITHOUT THE CLITORIS?—Dr. Robert T. Morris, in considering the above subject, advanced the following propositions:

1. The prepuce and the glans clitoridis are bound together by adhesions partly or completely in about 80 per cent. of all Aryan and American women.
2. Preputial adhesions are rare among negroes, and seem to occur only in a few of the individuals possessing a large admixture of white blood.
3. Highly domesticated animals do not present examples of the degeneration so far as the author's observations have gone.
4. When preputial adhesions are extensive, the glans clitoridis and the imprisoned mucous glands remain undeveloped, but they may develop later when the physician has separated the adhesions.
5. The failure of the embryonic genital eminence to properly develop the prepuce and glans clitoridis for perfect cleavage probably means that nature is trying to abolish the clitoris as civilization advances.
6. The degenerative process represented by preputial adhesions is characterized

by the civilized types of homo-sapiens, in which we find decaying teeth, early falling hair, and imperfect cornea and eye-muscles.

7. Preputial adhesions, which involve small portions of the glans clitoridis, are of interest simply as anatomical curiosities.

8. Preputial adhesions involving a large part or the whole of the glans clitoridis cause profound disturbance, and are among the most pronounced of the peripheral irritations. They cause desire for masturbation, which leads to neurasthenia, and they are responsible for grave reflex neuroses.

9. Preputial adhesions probably form the most common single factor in invalidism in women. The clitoris is an electric button which, pressed by adhesions, rings up the whole nervous system.

10. The physician who fails to examine the female child for preputial adhesions neglects the most important single duty of his professional life.—*Annals of Gynecology and Pædiatry*, January, 1893.

DIET IN DIABETES.—According to Dr. Leo, the limitation of carbo-hydrate food-stuffs up to their exclusion from the diet is looked upon as the first condition necessary in the treatment of diabetes, and the patients mostly improve under this regimen. This improvement is not always maintained. Notwithstanding the diminished amount of sugar in the urine, the patient loses ground. If a moderate amount of carbo-hydrate be then allowed, the general condition of the patient is often again improved. This is probably due to the increased appetite and the diminished burdening of the digestive organs with nitrogenous food-stuffs. Another point has, however, to be considered. There is no doubt that nitrogenous food-stuffs diminish nitrogenous metabolism. In most diabetics this nitrogenous metabolism is already much augmented, and the increased nitrogenous excretion contributes to the loss of strength, and must, therefore, be taken into account. In the investigation of two cases the author was able to demonstrate this albumin-sparing action of the carbo-hydrates in diabetes even of a severe type. Other observations have been recorded in which bread being allowed in moderate quantity, both the sugar in the urine and the quantity of the urine were increased, and yet the patient gained considerably in weight. The advantage is thus not merely a subjective but a real one. The author believes that this improvement is due to diminished nitrogenous metabolism brought about by the above-named action of the carbo-hydrates. Thus the limitation of carbo-hydrate food-stuffs is a most important matter in the treatment of diabetes, especially in the early stage, yet it may be a question as to how long it should be continued. The amount of sugar present in the urine should, of course, be frequently estimated, but it is quite incorrect to look upon the quantity excreted as the sole index as to the condition of the patient and the sole guide in treatment.—*Medical Record*, January 14, 1893.

HICCUGH.—One of the commonest of trivial personal discomforts, it is sometimes met with in the prostrate stages of certain diseases, where its import is always regarded as unfavorable, while its occurrence as the only manifestation of disease, as the one single symptom, or in fact as the essential disease itself, is probably one of the rarest of pathological states. As a clinical illustration, a case is cited which lasted ten days and nine nights, where hiccough persisted for 148 hours, averaging about 16 hours per diem, at the rate of 29 per minute, alternating with each respiration. During deep sleep, however, it sometimes occurred only every fourth breath. This gave a total of 257,520 spasms, depressing and exhausting a debilitated constitution difficult to describe. Among curious examples of hiccough Dr. Liveing cites one occurring for 12 hours twice a week for 4 years. M. Midal had a case of 19 days' continuous duration at the extraordinary rate of 55 spasms per minute. Dr. Watson gives an instance of an hysterical affection of the diaphragm in a girl sitting all day long on her bed uttering a loud and most discordant hiccough every eight or ten seconds. Dr. Good records "incessant" cases of 8 and 12 days, and one of even three months' duration; while Dr. Foot recites a case of a dyspeptic boy whose hiccough lasted without intermission for 26 weeks except during sleep, averaging 14 per minute. It was observed that the act of vomiting or the preparation for it, deranged its rhythm. He was cured (?) eventually by Indian hemp, iodoform and conium. He also describes a case of a girl who died of a hiccough and fright caused by the sudden execution by the police of a search-warrant in her bedroom. Most writers consider hiccough in the malignant and prostrate stages of some typhus and enteric fevers as an exceedingly grave sign.

The pathology of hiccough, for a long time a debated point, is now believed to be a reflex spasm of the diaphragm, with simultaneous closure of the glottis, having as afferent nerve the pneumogastric, and as efferents the phrenic (?) and recurrent laryngeal. According to Dr. Symes's clinical observation, the sympathetic connections of the semilunar ganglion seems far more likely to convey the impressions than the phrenic, for the following reasons :

1. The diaphragm appears to contract *before* the laryngeal muscles, pointing to a closer and more direct communication with the gastric portion of the vagus than even the recurrent laryngeal.

2. The course of the phrenic nerve is healthy and its respiratory function perfect.

3. The patient has no control over the spasm, while the phrenic is always subservient to one's will.

4. Remedies applied to the origin or course of the phrenic or to the cervical spine, such as blisters, ice-bags, compression, etc., have no effect, while those directed to the diaphragm, stomach, and solar plexus, are generally curative.

5. The connections between the pneumogastric and phrenic by means of the 3d, 4th, or 5th cervical nerves, are remote, and if this were the route taken the impression must travel more than double as fast on the phrenic as it does on the recurrent nerve, since it reaches the diaphragm before the larynx—which is unphysiological.

6. The experiences of Romberg and Bright, which show that direct irritation of the phrenic will not cause hiccough.

7. The existence of a perfect reflex-loop between the stomach and diaphragm, which more directly answers the purpose, separate from the function of respiration and beyond the control of the patient.

8. It being influenced by the acts of deglutition or vomiting to a greater degree than by any respiratory efforts.

During sleep it is less frequent. The impulses seem imperfectly transmitted or aborted, being only of sufficient strength to produce a true convulsion every second breath, while finally, by the deepest sleep, they are so weakened that the diaphragm may escape for four respirations the transmitted current from its afferent nerve. Hiccough is considered a typical example of a perfect reflex action, a true neurosis. The undoubted allaying influence of the act of swallowing is attributed to employing the pneumogastric for that purpose.

Of treatment little can be said. It is divided into (1) empirical, which includes almost every known drug or household remedy—the most efficacious being the *very frequent* acts of swallowing raw whiskey, vinegar, hot brandy punch, or a mustard blister over the epigastrium. (2). Antispasmodic, such as chloral hydrate, nitrite of amyl, calabar bean, cocaine, hydrocyanic acid, atropine, morphine or nicotine. (3). Physiological, this depending upon an accurate diagnosis of the conditions under which it occurs, of the constitution in which it is met with, and of the probable nature of the irritation to which the gastric or œsophageal branches of the vagus are subjected—as foreign bodies, accumulations, distension, worms, or specific morbid states of the viscera, such as gout, etc, each of which must in turn become the basis of a distinct and specific treatment.—Mr. W. Langford Symes, *Dublin Journal of Medical Science*, December, 1892.

CHRONIC INTERSTITIAL HEPATITIS.—Professor Liebermeister, of Tübingen, Germany, distinguishes two forms of interstitial hepatitis, namely, the portal and the biliary forms. The portal form is characterized by a proliferation of the interstitial tissue around the terminal twigs of the portal vessels. At first confined to the inter-lobular tissue it extends to the hepatic substance itself, the little islets of liver tissue becoming smaller and smaller possibly, finally, nearly to disappear. This induces quite a considerable diminution in size of the organ, though not always necessarily. For example, if developing in a previously fatty liver the decrease is not so perceptible. The next result of this is stasis in the entire portal vessels, with ascites, while the biliary vessels being but little implicated there may be but little or no icterus.

In the biliary form the inter-lobular biliary vessels and their immediate surroundings are the point of attack. They become obliterated, like the branches of the portal vein, by proliferation of the interstitial tissue, with a resultant increase in size of the liver as a result. The tissue has here a less inclination to retraction, although it extends over the hepatic tissue, hence there is less diminution in

size. In most cases it remains larger than normal to the end. The immediate result of the obliteration of the bile-passages is icterus, while ascites is liable to appear very late and then to a slight degree. A greater or lesser portion of the liver, or the whole organ may be implicated, the stools then being wholly colorless. Both forms, the portal and biliary, may set in at one time and ascites with a great degree of icterus be present. In both forms, excepting that in the biliary the liver is stained a darker and icteric tint, the anatomical relations are the same. The surface is nodular and granulated, of a yellowish or yellowish-brown appearance. The capsule is thickened in spots and villous excrescences and adhesions between the diaphragm and other organs may be remarked. The liver feels hard and firm, has a leathery consistence and creaks on section; from the cut surface oozes but little blood; the islands of hepatic tissue are surrounded by strands of interstitial tissue, of a grayish white or grayish red appearance. Here and there are spots where the hepatic tissue has completely disappeared. The cells themselves are passively engaged, degenerated more or less from fatty infiltration and deposition of pigment. The spleen is enlarged considerably, in some cases being ten times the normal volume. This increase is not due entirely to stasis, but hyperplasia, for in a case in the writer's clinic, where there was but little ascites, the spleen was found to weigh over half as much as the liver. In some cases the kidneys are also involved in the process, i.e., interstitial proliferation takes place. A slight degree of albuminuria may be observed.

This disease is especially liable to follow an abuse of brandy, while an excessive use of wine or beer is less disposed to cause cirrhosis. It has been observed by the author in those who denied drinking brandy but only weak alcoholic drinks, hence a chronic irritation from alcohol is the most frequent cause. Here the authorities agree, but on other causes there is a variance. Pungent spices, coffee and similar beverages have been accused of provoking the disease. In animals, by a chronic poisoning with phosphorus a granular hypertrophy of the liver has been caused. It is doubtful if this is an actual cirrhosis and in human beings cirrhosis has not been observed to follow poisoning by this drug. Chronic lead poisoning is also given as a possible cause. In syphilis and malaria it has been remarked as a complication. In the biliary form gall-stones appear, in some forms, to constitute a source of irritation and an ætiological factor. Males are more frequently attacked, the portal form being seen in elderly and the biliary in younger persons. Increase of the interstitial tissue is seen in other hepatic diseases; some cases of tuberculosis, especially miliary tuberculosis, if existing a long time, carcinoma of the liver and hepatic abscesses. In lung and heart diseases where there is a stasis in the circulation, cirrhosis may be observed, though this is not true cirrhosis. Both forms begin with indefinite symptoms that permit no definite diagnosis. The liver is enlarged, there is a sensation of swelling and pressure in the right hypochondrium, or the patient complains of disagreeable feelings in the abdomen and back, or dyspnoea. There is a certain amount of dyspepsia and the bowels are constipated. The general condition becomes worse, emaciation, weariness, a subicteric color of the complexion and depression of spirits appear. Then the characteristic symptoms of either form set in which are different.

In the portal form the most constant and important symptom is ascites; the spleen is enlarged, the left lobe is beginning to diminish in size, the edge of the liver projects beyond the border of the ribs, but is thin, and the surface of the liver in some cases, nodular. Other dropsical signs are lacking. Œdema sets in later. The ascites increases, the abdomen fills up and the liver is forced out of the diaphragmatic excavation and becomes freely movable. In some cases there are hæmorrhages from the stomach or bowels. These have been observed before the ascites set in, and, as they also appear in the biliary form and in parenchymatous degeneration of the liver they must be due to changes in the blood itself. The stools remain of the normal color, there is generally a slight degree of icterus, the urine being scantier and more concentrated as long as the icterus is on the increase. In some cases there is no jaundice; their skin is pale or pale gray and fawn-colored, dry and with an inclination to desquamation. Chronic catarrh of the stomach and intestines. At first there is no diarrhoea but a secretion of tough mucus and constipation, later obstinate diarrhoea sets in. If treated early properly, the disease may be brought to a standstill, or perhaps cured. The writer has a series of cases where this was attained. All depends upon a collateral circulation being built up to carry the blood around the liver into the vena cava—caput medusæ, etc. In most cases, this does not occur, the organ decreases in size and the portal terminals are obliterated.

The ascites increases, paracentesis becomes necessary more and more frequently, emaciation sets in and the patient succumbs, in a few years, to exhaustion and cardiac asthenia. Complications may hurry on the end. Hæmorrhages appear in some cases, either on the external skin, in internal organs, nose-bleed or repeated hæmorrhages from the mucous membrane of the stomach, intestines, respiratory tract or urinary passages. The heart may become weak and death take place with cyanosis and general dropsy. In advanced stages, as in other cachectic states, there is an inclination to inflammations of various organs so that the patient may succumb to a pneumonia, pleuritis, pericarditis, peritonitis or even erysipelatous and phlegmonous inflammations of the skin. The disease itself is feverless. The hope of the patient is that a collateral circulation will be set up that will carry the blood around the liver into the vena cava.

In the biliary form of the disease, seen less frequently, the first and most striking symptom is the appearance of icterus, which continues to a great degree; finally, in some, to pass into the so-called melanicterus. In some cases, hæmorrhages from the stomach or intestines usher in the disease. The stools are not entirely colorless at first, but later, when even the smallest gall-passages are obliterated, the stools are completely colorless. Ascites is, at first, generally absent, and rarely reaches such a degree as in the portal form. The liver is, in most cases, quite enlarged, even to double the normal; in the later stages it may decrease in size to even below the normal. The spleen is enlarged, often to a great degree. The further course of the disease is the same as in the portal form, except that the symptoms of disturbance of the portal circulation are less prominent, and those due to obliteration of the bile-passages more so. In the biliary form there is a tendency to acute degeneration of the hepatic cells, so that death takes place with cholemic symptoms and a hæmorrhagic diathesis. The diagnosis of the portal form offers no great difficulties. Ascites, with an enlargement of the spleen and decrease in size of the liver, including a previous history of abuse of alcohol, will generally suffice. A preceding hæmatemesis, if not due to cancer or ulcer of the stomach, will serve to clinch the diagnosis. In its incipency, it is a more difficult matter to recognize.

A mobile ascites, increase in size of the abdomen, pressure in the hepatic region, dyspepsia, enlargement in size of the spleen, constipation and an alcoholic history, together with a fawn-colored skin and a tendency to icterus in the sclerotic, will lead one to suspect cirrhosis. Adhesive pylephlebitis may simulate cirrhosis, yet it is a rare disease. It is observed in cases where there are other affections of the portal system. The symptoms develop more rapidly and the ætiology is different. The so-called atrophic nutmeg liver is easily distinguished. It appears in long-lasting heart or lung diseases, where a stasis has long existed, with œdema of the dependent portions of the body. Hyperæmic swelling of the liver sets in, and, later, ascites, and decrease in size of that organ. A chronic peritonitis, with a serous or sero-fibrinous exudate, as is seen, secondarily, in chronic peritonitis following malignant tumors or tuberculosis of the peritonæum, may simulate the disease to such an extent as to confuse one, but it may come without any such cause. There is painfulness of the abdomen and evening fever, while the alcoholic history is wanting. The spleen is normal. If the fluid tapped is clear and of a low specific gravity, 1013 and under, it is probably no inflammatory exudate but a transudate; if thick and turbid from cells and fibrine, and of a high specific gravity, it is certainly an inflammatory exudate. The biliary form presents great difficulties in the diagnosis. The icterus and swelling are observed in such a number of affections that, in the beginning, a certain diagnosis is impossible. It is to be thought of when the icterus persists, gradually becomes more intense when there is an enlarged spleen and when no compression or obstructing gall stone can be discovered, while the usual alcoholic history is not lacking. Multilocular echinococcus of the liver is distinguished with difficulty, for here there is both a portal and a biliary form, with ascites, and with icterus. Necrotic cavities sometimes arise in multilocular echinococcus affections of the liver which permit a trial puncture.

As to the treatment, the alcohol must be discontinued, and possibly, for a time, replaced by weaker beverages. A rigid Carlsbad "cure" is carried out. Every morning, before breakfast, the patient is to drink a pint of warm water, in which enough Carlsbad salt is mixed to produce two thin stools, and then remain fasting for one and a half hours. Acid and fat foods, green vegetables and fruit, are to be avoided, together with strong coffee, tea and spices. After four weeks this is discontinued, and the bowels kept regular for two weeks, when the "cure" is com-

menced again if required. Fluids and especially milk diet are indicated. The alcoholics must be discontinued, and if the patient has the moral courage to leave them off the prognosis is not so grave as is thought. If the ascites increases, then try paracentesis, but do not delay until the last moment. Draw off enough till the abdomen is soft and compressible, but not all the transudate. The biliary form is generally first seen in an advanced stage. The same treatment improves the icterus, and a large amount of water drunk ameliorates the disagreeable itching. The milk diet is especially to be recommended.—*Deutsche Medicinische Wochenschrift*, No. 42, 1892.

DYSPEPSIA AND HEART DISEASES.—Professor Potain, of Paris, recently considered the inter-relation of heart disease and dyspepsia, in a clinical lecture. In certain cases of heart diseases the dyspeptic symptoms entirely mask the original affection, obscure the diagnosis and lead one astray. Yet there are two kinds of dyspepsia which here come into consideration: a dyspepsia due to heart disease and heart disease dyspepsia. The former is the more frequent of the two. There is no heart disease which is not accompanied by a more or less anomalous condition of the digestive tract, due to circulatory disturbances. Asystolia is associated with a blood-stasis and consequent malnutrition of the walls of this organ so that a dilatation is liable to take place. Later, when all the other organs are affected by this sanguinary stasis they react upon the stomach especially, and aggravate its morbid condition. The liver, lungs and kidneys functionate badly and their products of excretion disturb digestion and contribute to the fatal result. In the initial period the treatment is able to modify this dyspepsia, while in the latter stages all treatment is useless. At first the cardiac affection may be held at bay for quite a time, for then the stomach disturbance is but reflex from the heart disease. Digestion is slow, laborious, the patient complains of nausea, a sensation of weight and epigastric pain, constipation, flatulence, and actual crises of enteralgia, with colic and diarrhoea may be observed. These gastralgic pains are often the first symptoms of a heart disease. (See Jousset, *Heart Diseases*.) Dyspepsia, pure and simple, may be the cause of a heart disease. It has been explained by the pressure of the distended stomach upon the heart. The lecturer is not of this opinion, but rather ascribes it to reflex influence through the sympathetic or pneumogastric nerves. [Toxines.—Eds.] When the pneumogastric is the path of these reflexes, a considerable disturbance of regularity in the heart beats is remarked. There is arrhythmia, tachycardia, precipitated beating, intermittence, etc., which are very painful and impress one that he has an organic affection of the heart before him. When the sympathetic is the track taken the symptoms remind one of circulatory troubles, due to tricuspidian insufficiency. There are certain cases where the stomach disease reacts upon the heart disease and greatly aggravates it. For example, in certain subjects an aortic insufficiency or lesion remains latent until as long as the stomach performs its functions normally, but when these react reflexly upon the stomach the latter becomes diseased and the heart muscle, being less well nourished, is unable to keep up its work and the system suffers. The heart degenerates, which lesion is most frequently not to be remedied. Sometimes the two states are associated simultaneously, especially in those heart patients who live on bad food and above all, those abusing alcoholics. These are chiefly women who, beginning with small doses, pass on to stronger ones and, the alcoholic dyspepsia being established the degenerescence of the myocardium is hurried on. The heart symptoms may so mask the stomach disease that the stomach is neglected.—*Le Bulletin Medical*, No. 84, 1892.

PRIMARY TUBERCULOUS PERICARDITIS.—Professor Virchow claims this to be one of the rarest diseases. His first case was that of a man, 80 years of age, who presented no traces of tuberculosis in other parts of the body, and in whom the pericardiac eruption of tubercles was the only seat of the disease. Most of the cases ran a similar course, though in the majority such a hæmorrhage had taken place into the pericardium that, at first sight, one would have thought the heart to have ruptured. Such a case often will be diagnosticated as hydro-pericardium. The legs will be œdematous, with ascites and exudation into both pleural cavities. There will be no fever and slight dyspnoea. The abdominal and pleural exudates are serous, while the pericardium is tensely filled with a dark, thin, hæmorrhagic effusion. The whole heart is hypertrophic, the pericardium enormously distended. Fibrous as well as hæmorrhagic exudation is present, and a large number of tuber-

cles are found in the pericardium and heart. The hæmorrhages are due to the formation of new bloodvessels, as in hæmorrhagic pachymeningitis. In such cases there is always a protracted pericarditis, running chiefly a latent course, which is at first fibrinous, then adhesive, and, finally, sclerotic changes occur, the new tissue becomes very vascular, new paroxysms follow with hæmorrhagic products, and, at the same time, the tuberculosis may, by extension, involve the pleura, etc.—*Berliner Klinische Wochenschrift*, No. 51, 1892.

TREATMENT OF RINGWORM.—Crawford Warren suggests the following treatment for this troublesome affection: The affected region should first be washed with soap and warm water containing a little carbonate of soda, and well dried. Acetic acid should then be thoroughly applied by a small brush, and on the lapse of five minutes when the acid will have soaked into the part, an ointment composed of sixty grains of chrysophanic acid to an ounce of lanolin should be rubbed in. This treatment should be carried out daily for such a period as may be necessary.—*Journal of the American Medical Association*, November 12, 1892.

GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D.

INTRAPERITONEAL LIGATURE OF THE EXTERNAL ILIAC ARTERY FOR INGUINAL ANEURISM.—Makins (London) operated such a case by the transperitoneal method with success. There was an oval, pulsating tumor in the *left* groin, extending upward from Poupart's ligament about one-third the way to the umbilicus, and some two inches downward into the thigh. The abdomen was opened in the linea semilunaris, and the deep epigastric artery, which originated in the tumor, ligated. The sigmoid flexure was pushed upward and an incision made through the lower part of its mesentery and the peritonæum along the brim of the pelvis. An abundance of sub-peritoneal fat made the wound quite deep, and the spermatic and mesenteric vessels swelled up after losing their peritoneal support, making access to the artery difficult. The vessel was tied with a double ligature, of stout flossy silk, about an inch below the bifurcation of the common iliac, and about two inches above the aneurismal sac, the posterior peritonæum sutured, and the abdomen closed. The wound healed kindly. Pulsation in the aneurism ceased at once; the front of the thigh was cold, but the circulation in the foot was good throughout. Pulsation in the tibials was present at the end of a week.

On the same day, Banks (Liverpool) also ligated the *right* external iliac in the same way. The operation is much more easy on the right side, as the vessel lies directly beneath the peritonæum, and is not covered by any structure of importance. On the left side, however, the inferior mesenteric and spermatic vessels cover the artery, and, to get at the common iliac, the peritoneum should be divided close to the middle line and pushed outward. The external iliac is usually best tied through the extra-peritoneal incision, but the transperitoneal route is to be preferred when there is a doubt, as either the common or external iliac is then accessible.—*London Lancet*.

PUNCTURED WOUNDS OF THE SUBCLAVIAN VESSELS.—Rotter (Berlin) reports the case of a young man who received a stab in the subclavian region. The profuse hæmorrhage resulting was arrested by pressure. A loud blowing sound could be heard over the vessels, and the wrist pulse was small and weak. An extensive secondary hæmorrhage took place on the ninth day. A small tumor was exposed, after temporarily resecting the clavicle, and the subclavian ligated above and below this, when the hæmorrhage ceased. The skin of the extremity became cold, the pulse could not be made out, and the mobility of the fingers and shoulder was impaired. Recovery was uneventful, however, and four months later the patient was pursuing his business.

Punctured wounds of the subclavian are rare, there being but twelve reported in the literature of over a century; but any physician may be suddenly called upon to treat such an accident. The diagnosis is usually difficult, as the primary hæmorrhage has ceased, and the testimony of laymen as to the amount is unreliable. When

the artery alone is injured, there will be a large hæmatoma; when the vein alone is involved, the tumor will be small as is also the case when both vessels are punctured and some of the arterial blood passes into the vein. If the artery is completely severed the pulse is lost, and it is faintly felt when the collateral circulation is established. If the artery is punctured, the peripheral circulation is not interrupted, but a systolic murmur is heard at the point of injury. In arterio-venous aneurism the murmur is louder, and can be heard at a greater distance from the wound; there is fremitus, also a venous pulse. The secondary hæmorrhages, too, are of importance, but operative interference should be undertaken before they occur, in fact, during the first day; the hæmatoma renders operation much more difficult, and it may break down and suppurate. The vessel may be ligated by the method of Antyllus, or that of Hunter, and temporary resection of the clavicle greatly facilitates the steps of the operation.—*Münchener Medizinische Wochenschrift*.

RUPTURE OF THE FEMORAL ARTERY.—Zuckerkancl (Vienna) in forcibly correcting a malposition (adduction, flexion and inward rotation) met with this accident. The patient, a young man, had an old coxitis and a fistula running from the inner surface of the thigh to the joint. As a preliminary to operation on the joint, the deformity was reduced with comparative ease under chloroform. A tumor appeared in the upper part of the thigh and rapidly grew to the size of a child's head. It was incised, and a quantity of blood evacuated, showing the femoral artery torn across just below Poupert's ligament. The two ends were ligated and the patient recovered. The vein and nerve were intact.—*Wiener Klinische Wochenschrift*.

TRAUMATIC NON-SUPPURATIVE PERITONITIS IN CHILDREN.—Sutherland (London) reports two such cases occurring in the practice of Watson Cheyne:

(1) Babe of 12 months, tapped for right congenital hydrocele four weeks previously. Within a few days the abdomen had become swollen; was tense and tender, fluctuated, and was dull on the right side. The temperature was high and rising (101°–104°), the pulse rapid (146), and the child markedly anæmic; the hydrocele had reappeared. The latter was again tapped and then the abdomen, some twelve ounces of blood-stained serum being drawn off. The hydrocele refilled, the abdominal swelling persisted, and the temperature kept up. The abdomen was opened in the right linea semilunaris and a quantity of blood stained fluid evacuated. By pushing the finger through a thin membrane another accumulation of similar fluid was found, the cavity of this sac communicating with the tunica vaginalis. The wound was closed with drainage, and the child made an uninterrupted recovery. The amount of blood found was out of all proportion to the extent of the presumable injury, the tapping, but showed its effects by the pronounced and progressive anæmia in a hitherto well-nourished and vigorous child.

(2) Girl, 8 years old, was run over by a wagon, the wheel passing over the abdomen. This became distended and tender, particularly in the epigastrium. The thighs were kept flexed, and the breathing was entirely thoracic. There was thirst and vomiting of food. The acute symptoms subsided in about three weeks, but the temperature kept up, and there developed a fluctuating tumor in the epigastrium. This was tapped, and ten ounces of dark green fluid, containing red blood-corpuscles, withdrawn. Recovery followed.—*London Lancet*.

PERFORATING GASTRIC ULCER.—Krieger reports the first successful laparotomy for gastric ulcer opening into the free abdominal cavity, there being six failures recorded. A number of cases have been successfully operated when protective adhesions had produced an encapsulated abscess. The diagnostic points are a previous history of gastric ulcer, suddenly developing peritonitis, and the presence of air in the peritoneal cavity obliterating the hepatic dulness. Vomiting is often absent, and the pulse but slightly increased. Exploratory laparotomy is permissible, and early operation should be the rule (Kuh and Rydiger), the only contraindication being extreme collapse. The evacuated gas is odorless, with but slight septic properties, and the peritonitis of the progressive fibro-purulent variety (Miculicz). Such cases of perforative peritonitis, when left to themselves, are, as a rule, hopeless (Ewald and Leube). A large proportion of the ulcers situated on the anterior wall of the stomach perforate (85 per cent., Brinton). Another favorite seat is the cardiac end. Those on the posterior surface rarely perforate (2 per cent.). When the extruded contents of the stomach do not point to the lesion, the anterior surface up to the lesser curvature should be carefully examined, then the cardiac end, and, finally, the gastro-colic omentum torn through to get at the posterior surface. If the ulcer

is readily accessible, it should be excised entire, or its edges at least freshened. Otherwise, suture of the edges will answer. Exuded gastric contents and pus should be carefully mopped up; irrigation only diffuses the septic process. Iodoform gauze drainage is preferable. After the operation the stomach should have absolute rest, the patient being kept up by rectal alimentation. Morphia and opium suppositories are useful adjuvants. Purulent, left-sided pleurisy is a frequent complication and should be looked for. Surgical interference holds out considerable hope in these cases, as it does even in the intestinal perforations of typhoid fever (Krecke).—*Berliner Klinische Wochenschrift*.

STRANGULATED OBTURATOR HERNIA.—Wyman (Detroit) recently operated such a case. The patient, a thin old woman, presented the usual symptoms of bowel obstruction with fecal vomiting, and an indistinct tumor beneath the muscles in the bottom of Scarpa's triangle. The patient had noticed the tumor for some time. An incision was made in the long axis of the thigh, a trifle lower than that used for femoral hernia, and carried down to the pectineus muscle. This was pushed aside, and the sac isolated and found protruding from the upper portion of the obturator foramen. The sac was very thin, and contained a very small quantity of omentum and a knuckle of gut, probably only a part of the intestinal lumen being protruded. The constriction was divided toward the median line to avoid the vessels which run toward the acetabulum, when the intestine and omentum at once slipped out of reach into the abdomen. The wound was packed and healed by granulation. The bowels were freely moved within two hours, and the patient made a rapid recovery.—*Annals of Surgery*.

EXCISION OF THE UPPER RECTUM AND LOWER SIGMOID FLEXURE.—Maunsell (London) proposes a new method for excising the two upper thirds of the rectum or the lower segment of the sigmoid flexure of the colon. Any lesions above this point can be reached through an abdominal incision, while those below are readily accessible from the anus.

With the patient in the lithotomy position the sphincter is divided backward, a speculum introduced, and the rectum dilated. The abdomen is opened, the gut to be operated isolated, and any fecal accumulation pushed back into the colon. With a long packing-needle a piece of broad tape is passed through the proximal side of the growth, first on one side and then on the other, and the ends drawn out of the anus. The recto-vesical or recto-uterine fold of the peritonæum is incised, and after drawing out the rectum to make its peritoneal attachments tense, these are divided with probe-pointed scissors. By traction on the tapes the bowel is invaginated and drawn out of the anus. The bladder is located and kept out of harm's way by the introduction of a catheter. The middle or returning layer is divided as high up as possible all around, to free the inner or entering layer. The latter is drawn down until the limits of the disease are passed, and amputated, after the inner and middle layers have been transfixed with two fixation needles. By twelve passages, at least half an inch from the free edges, of a long needle threaded with chromicized catgut, the threads being picked up in the middle of the invagination, divided and tied on both sides, twenty-four sutures are applied. The colon is douched and emptied of its feces, the sutured surface painted with Wölfler's mixture, the bowel returned, the divided rectal peritonæum sutured, and the abdomen closed.—*London Lancet*.

A NEW OPERATION FOR PARALYTIC TALIPES VALGUS.—Parrish (New York) proposes as a surgical principle the advisability of grafting the tendon of a paralyzed muscle on that of a healthy one, so as to make the latter do the work of the former, alone or with its own. This is particularly applicable to the paralytic deformities which are met with in the leg and foot. The muscles most frequently affected are the anterior and posterior tibials, those of the calf, and the peroneals, in the order named. In talipes valgus, as a rule, the extensor proprius pollicis is not affected.

Experiments were made on the cadaver as follows: After isolating the anterior tibial and extensor pollicis muscles, the foot was inverted and extended, and the shortened tendon of the former was sewed to the lengthened tendon of the latter. This was done both above and below the annular ligament on different subjects. The foot was then everted, and by pulling on the extensor pollicis the eversion was corrected, the arch raised, and the great toe extended. The result was the same in both experiments.

A girl of four years was then operated. She had had infantile paralysis when a

year old, and both tibial muscles were paralyzed, producing a talipes valgus. The extensor pollicis was moderately strong. A three-inch incision was made between the anterior tibial and extensor pollicis tendons above the annular ligament. The tendons were isolated and the sheaths cut away. The foot was inverted and extended, and after freshening their adjoining surfaces for the space of an inch or more, the shortened tibial tendon was fastened to the stretched extensor pollicis tendon with catgut. The foot was moulded into position and put up in plaster of Paris for a month. Healing was good, and the position of the foot much improved. The adhesions were broken up by massage, etc. The final outcome will be reported later on.

In some cases the tendon of the extensor pollicis can be divided and fastened to the extensor longus digitorum; then the anterior tibial tendon can be divided and its distal end attached to the extensor pollicis. When the posterior tibial is paralyzed its tendon may be sewed to the tendo Achillis. In paralytic talipes calcaneus, the tendo Achillis can be attached to the tibialis posticus, the flexor longus pollicis or digitorum; when the common extensor of the toes is paralyzed, the extensor pollicis or the tibialis anticus may be brought to its aid. In this way the use of the principle may be greatly extended. In every case the deformity should be made readily reducible. As a rule, the inflammatory adhesions resulting from the operation will give way to manipulation and electricity, and the muscle that has extra work to perform will be strengthened in the same manner. If the adhesions do not give way, the foot will at least be held in an improved position, and the patient enabled to walk without artificial support.—*New York Medical Journal*.

EPICYSTOTOMY.—Jaboulay has found that when it is desired to form an artificial supra-pubic urethra, by making the opening through the rectus (right) muscle a sphincteric action is obtained and the sinking in of the orifice is avoided. The bladder wall and skin are united by stitches the muscles not being included.—*Le Mercredi Médical*.

TREATMENT OF ACTINOMYCOSIS BY IODIDE OF POTASH.—Van Itersen (Leyden) has successfully treated two cases of actinomycosis with the iodide of potash.

(1) Tumor of the floor of the mouth which did not invade the submaxillary region and had existed for several months. No microscopic examination was made but the appearances were very characteristic. During eight months about eight ounces of the drug were administered in doses varying from seven to thirty grains per diem. The cure was complete.

(2) Tumor in right iliac fossa, diagnosticated as perityphlitis. Yellowish nodes were discharged with the pus, which were shown by the microscope to be actinomycotic rosettes. For two weeks fifteen grains of the iodide were given daily. At the end of this time the patient was discharged cured. Six months later he was in good health. The results obtained by Thomassen and Nocard with the iodide of potash in actinomycosis of cattle led to the use of the drug in these cases.—*La Semaine Médicale*.

THE AVOIDANCE OF SCAR IN THE TREATMENT OF CERVICAL ABSCESS.—Briggs (Boston), to avoid a long, ragged scar, recommends, instead of the customary free incision in very large collections of pus, the following procedure:

(1) Enlarged, red, faintly fluctuating gland in upper cervical region. After a month of anti-syphilitic treatment, there was a large abscess and a breaking down of the glands lower down the neck. The abscess was opened by a quarter inch incision, curetted with a very small spoon, syringed with creolin, and drained with a wick of gauze. At the end of three weeks two small openings were made into the abscesses lower down, and all the cavities found to communicate, making a sinus extending from the root of the neck to the mastoid process. They were similarly treated. Every day subsequently the curetting was repeated, bringing away more or less gland tissue for four weeks. A tendency to closure of the sinus with pocketing of pus was prevented by the use of olive-pointed urethral bougies. The cure was complete in six weeks with three small stellate scars.

(2) Enormous abscess of the front of the neck, extending from the jaw to the clavicle. The pus was evacuated through a very small incision, which was kept open until healing was complete. The curette was not used but the cavity was washed out with creolin. The scar was barely visible.—*Boston Medical and Surgical Journal*.

GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D. AND J. NICHOLAS MITCHELL, M.D.

THE OPERATIVE TREATMENT OF RUPTURED TUBAL PREGNANCY.—Professor Gusserow sums up his experience as follows: Laparotomy should be performed immediately if there are indications of internal hæmorrhage progressing with a certain amount of severity, or if it occurs during the observation of a hæmatocele. The operator should not hesitate on account of the uncertainty of diagnosis in many cases and a temporary improvement of the patient. The operation should be performed in a private hospital whenever possible as the danger of transportation is more than compensated by the security given by asepsis. Loss of time is not to be considered as the preparations for operating are quickly made in a hospital.

The conditions attending extra-uterine pregnancy are very difficult to diagnose in many cases and then the patient should be treated by absolute rest and most watchful observation. Gusserow particularly recommends immediate laparotomy when there are indications of a ruptured hæmatocele.—*Schmidt's Jahrbücher*, No 11, 1892.

EFFECT OF CHOLERA ON PREGNANCY.—Tipjakoff reports his experience in the late epidemic as follows: All the pregnant women entered the hospital in the beginning of the disease and in every instance pregnancy was terminated as the disease progressed. The uterine contractions began at about the same time as the cramps, but in one case abortion did not take place for some time as the cramps were tardy in developing. In three cases where motion had been felt, no vigorous motion was felt in the first stage and after the prostration of the mother's strength, the motion of the child gradually became weaker.

Uterine hæmorrhage appeared soon after the uterine contractions in every case, but in only one was it of any consequence. The period of dilatation was short and rapid, but the expulsive period was slow owing to absence of pains. There was no bleeding in this stage but some bloody slime escaped. The foetus died before the cervix was fully dilated.

In all cases, with one exception, the placenta came away with a black blood clot in its centre. There was no post-partum hæmorrhage and the uterus contracted vigorously. Six out of seven patients died and one primipara lived. In this case the puerperal period was normal but the lochia were scanty and involution was slow.

Non-pregnant women showed on post-mortem examination large long blood clots in the uterus and hæmatosalpinx was found in two cases. There was a very marked hyperæmia of the serous covering of the uterus and in the tissue of the latter, numerous bloody extravasations the size of pin heads. The endometrium was very hyperæmic. Hæmorrhage in the perirectal tissue was found in one case.

The pregnant uterus was hyperæmic on the exterior with small hæmorrhages in its substance, some anæmia of it, and large black clots at the placental site.

The microscopical examination showed there was no infiltration of the uterine tissue with white blood corpuscles as is found in endometritis.

He believes the appearance of the uterus is due to mechanical causes. The cramps prevent exchange of gases, hinder the flow of blood to the periphery and congestion of the internal organs is the consequence. The bloodvessels are unable to withstand the blood pressure and rupture. Extravasations of blood irritate the tissue and may excite inflammation but this is of a secondary and not a primary character. In pregnancy, the prevention of exchange of gases and the accumulation of carbonic anhydride causes uterine contractions, but the rupture of the bloodvessels and hæmorrhage between the uterus and placenta destroys the foetus in utero. He was not able to prove that the child died from the cholera poison itself, but rather from the increasing prostration of the mother, the prevention of gas exchange and hæmorrhage between the uterus and placenta.—*Centralblatt für Gynäkologie*, No. 40, p. 782, 1892.

ECLAMPSIA.—The general opinion now, in Germany, is, that eclampsia should be regarded as a result of poisoning of the blood by substances which circulate in the latter, causing symptoms, such as convulsions, rise in temperature, etc. It is not yet possible to decide whether the inflammation of the kidneys, always present, is primary, and the retention of substances which have been formed in the body

itself is caused by this, or whether the poisonous substances are external invaders and give rise to nephritis, as they are excreted. In the most recent times, the opinion has gradually gained ground that the last theory is the true one, and an attempt has been made to seek in bacteria the noxious cause of eclampsia in pregnant women; nevertheless, up to the present time, these are only investigations which do not even give an appearance of probability. Ten years ago, Lochlein estimated the mortality at thirty-two per cent.; he now gives it at nineteen per cent. Olshausen lost twenty per cent.; the Charité, eighteen and seven-tenths per cent.; Goldberg, twenty-four and seven-tenths per cent.; so that the mortality can be fixed at about twenty per cent. The prognosis becomes worse as the number of convulsions increase. If more than fifteen convulsions, the prognosis is unfavorable. With frequent attacks, the prognosis is only favorable if the course of the affection is slow. The more severe each convulsion is, the worse is the prognosis. Eclampsia, with a temperature above 39°C . ($101\frac{1}{2}^{\circ}\text{F}$.), has double the mortality of that without fever; in all cases with a fatal termination, the pulse is greatly increased in frequency, even after the first convulsion. The prognosis for children is, according to Lochlein, a mortality of thirty-seven and three tenths per cent.; according to Olshausen, after subtraction of unviable children, twenty-eight per cent.; according to Goldberg, thirty-seven and six-tenths per cent. The chief cause of this mortality is the number and quick succession of the convulsions; after twelve or fifteen attacks, the fetus is usually dead. The unfavorable influence of large doses of narcotics, especially morphine, used for controlling the convulsions, is often observed. The first dose of morphine should be 0.03 grammes ($\frac{1}{2}$ -grain). It is seldom that more than 0.06 grammes (1 grain) is used, altogether. Olshausen uses little chloral, and recommends chloroform only in those cases where it is desirable to control convulsions immediately.—Dr. G. Winter, in *Annals of Gynecology and Pædiatry*, September, 1892.

SEA-BATHING IN CHLOROSIS AND ANÆMIA.—Cold sea-baths are contra-indicated in anæmia complicated with diseases of the important organs, or, in anæmia which has led to great debility and anorexia. The latter is soon removed by sea-air.

1. Anæmic patients should not bathe at all for two days after arrival at the sea-shore.
2. They should never bathe fasting.
3. They should not take baths every day.
4. The first bath should not last over one minute; later on, they may be extended to three or four minutes, but never longer.
5. The bather should undress rapidly, and dip into the waves immediately, without waiting for the body to cool.
6. The patient should not move about, but remain as passive as possible while in the water.
7. No baths are to be taken in stormy weather, to avoid over-exertion.
8. After each bath, the patient must be carefully dried, and have the skin rubbed.
9. The patient should not exercise, but rest in bed for an hour after each bath.
10. As a rule, anæmic patients should not bathe oftener than every second day.
11. No object is attained by beginning the sea-bath treatment with warm baths. They may do harm. An exception hereto is in parametric exudations; in these, warm sea-baths may be used with warm wet packs of the abdomen during the night, associated with abdominal massage. These, together with prolonged stay in the sea-air, prove efficacious.
12. The patient should not exercise much at the sea-shore; even sitting there for an occasional hour proves sufficiently tiring.
13. Patients with profound anæmia should limit walking to the absolutely necessary; they should sit or lie, well wrapped, in the open air for the greater part of the day.
14. The insomnia which often sets in while at the sea-shore is most frequently due to over-exertion.
15. Preparations of iron assist, especially in the beginning, and are, in most instances well borne at the sea-shore. The most durable form is saccharinated ferro-carbonate; but the use of ferruginous waters at the sea-shore is not appropriate in anæmia.
16. The patient should not yield to the extreme appetite which often sets in at the sea-shore, lest the stomach soon becomes unable to perform its functions.

17. Alcoholic stimulants should be used most sparingly; patients should be warned against brandy and heavy wines. Alcohol furthers fatty degeneration of the muscles, and particularly of the heart.

Three hundred cases treated with above precautions proved the efficacy of sea-baths in anæmia.—Kruse, *The Archives of Gynecology*, 1892.

THE ÆTIOLOGY OF INTRA-UTERINE FRACTURES.—Max Sperling arrives at the conclusion that the cases of so-called intra-uterine fractures are very frequently defects of development, and not actual fractures. These defects should not be considered as either cause or consequence of fracture, and are due to a common cause, such as some kink, bend, or flexion as early as the first or second month of embryonal life. Amniotic adhesions or bands are probably the cause of the anomalies of development. The shortening and prevention of the development of the extremities in so-called intra-uterine fractures is explained by the kinking of non-differentiated blastoderm, producing anomalies of nerves and vessels. The existence of cicatricial tissue is no proof of an intra-uterine fracture on account of the rarity of careful observations of it; the great variety of descriptions of such alterations of the skin; the entire absence of microscopic evidence of the presence of similar alterations of the skin in other deformities, such as spontaneous amputations. The existence of these cicatricial-like alterations of the skin are readily explained as the effects of amniotic threads. The mechanical conditions within the uterine cavity are such that it is very improbable a fracture of the femur would occur from a blunt force from without, as it would be very difficult to imagine both ends of the femur fixed at the same time. The liquor amnii affords excellent protection from external force. If intra-uterine fractures are to be explained by intra-uterine pressure, the fracture would be most likely to occur during an intra-uterine contraction, but no case is known where the uterine contractions have produced a fracture in the first stage of labor. There is very little or no callus formation in intra-uterine fractures, contrary to what one might expect, except in the so-called intra-uterine fractures of the clavicle, and here the callus formation is readily explained by the kinking in the two first months, and the early ossification of the clavicle in its first stages. This last explanation does not hold good for the lower extremities, but accounts for the absence of the callus formation, as the kinking precedes the beginning of ossification.—*Zeitschrift für Geb. und Gynäk.*, Bd. xxiv, H. 2, 1892.

A NEW METHOD OF TREATING ASPHYXIA IN CHLOROFORM NARCOSIS.—Winter reported a method to the Obstetrical and Gynecological Society of Berlin which he had seen in König's clinic, in Göttingen. Maass, an assistant of König, treated a very severe case successfully by it. The patient had been worked over for an hour without any result; respiration and pulse had entirely ceased, but by rapid, rhythmical compressions (about one hundred and twenty per minute) of the cardiac region, the heart's action gradually increased, and the patient recovered. A second case responded in a similar manner. Maass ascribes the effect of the cardiac compressions to driving the blood into the larger arteries, as, with each compression, he could detect a synchronous weak pulse in the carotids. Winter reports another case, in which he tried the method. The patient became asphyxiated before the operation, and respiration ceased but was restored by artificial respiration. She breathed regularly, and the color of the face was normal, but the heart ceased absolutely, no pulse could be felt or heart-sounds heard, the respiration became slower, and superficial and slight cyanosis appeared. At this stage, Winter employed Maass's compressions rapidly and energetically about twenty to twenty-five times, when the pulse gradually improved, respiration commenced, and the asphyxia disappeared. He believes it a valuable method of restoring asphyxiated children after birth. Olshausen, and other members of the society, expressed themselves in favor of this method.—*Zeitschrift für Geb. und Gynäk.*, Bd. xxiv, A. 2, 1892.

GONORRHOÆAL INFECTION AND ITS CONSEQUENCES IN THE FEMALE—Bumm cannot agree with Nögerath and others that the infection readily extends to the tubes and peritonæum, but that the external and internal oses form barriers to the extension of the disease. Menstruation, the puerperium and therapeutic manipulations favor the spread of the disease to the uterine cavity. The infection of the uterine cavity is shown by chills and fever, severe uterine colic and a bloody serous discharge which later becomes purulent. In both the acute and chronic stages there is much sensitiveness of the organ due to frequent exacerbations of the inflammatory processes. If the inflammation spreads to the tubes the peritonæum will

soon suffer—not from a genuine gonorrhœal infection or form, as the serous surfaces afford poor nourishment for the gonococci—but it is rather of a septic character, such as is seen in inoculating the peritonæum of rabbits with fresh gonorrhœal pus. Bumm believes that the tubes are infected in less than a third of all cases.—*Centralblatt für Gynækologie*, No. 37, 1892.

SYMPHYSEOTOMY.—Leopold reports two cases and believes that in relative indications it may replace perforation of the living child and Cæsarian section. The latter should be restricted to absolutely contracted pelves, six c.m. for conjugata vera or less for full-term pregnancies. The mortality of Cæsarian section is higher than that of perforation and symphyseotomy. Of 0 per cent. to 5 per cent. of some Cæsarian section operators, Leopold finds that symphyseotomy is not difficult. He places the patient on a table with the hips projecting over the edge. Every preparation is made for the completion of delivery by version or forceps. Two assistants support the knees, which are a little separated, and with the upper hand press the trochanters firmly together. The skin is cut over the upper edge of the pubic bones within one centimetre of the clitoris. The soft parts are separated to the joints and the insertion of recti muscles separated transversely just enough for the left forefinger to pass behind the pubic symphysis as far as the ligamentum arcuatum. With the finger in this position for a guide the joint is slowly separated with a curved probe-pointed bistoury. The bones immediately separate about three centimetres, and with very careful separation of the knees and slightly relaxing pressure over the trochanters the symphysis will separate seven centimetres, allowing easy extraction of the child with the forceps.

When delivery is accomplished, both assistants press the parts together, and the soft parts are united with silver wire or very strong silk. A very broad and firm laced girdle is worn for three weeks and drawn a little tighter each day. It is not necessary to divide the ligamentum arcuatum or even more than one-half or two-thirds of the symphysis for a separation of three centimetres. No more separation should be allowed than is necessary for the delivery of the child.—*Centralblatt für Gynækologie*, No. 30, 1892.

SYMPHYSEOTOMY.—Dr. Porak reports an operation performed in the Lanboisière Hospital, on a woman suffering from rickets, who had been in labor for some twenty-four hours, and where the application of the forceps failed to deliver the child, which presented in the R. O. I. T. After thorough antiseptic vaginal injection, and shaving and rinsing carefully the external parts, a sound was passed far enough into the bladder to keep that organ away from liability of injury. An incision of five to six centimetres laid bare the symphysis, when the triangular ligaments were separated enough to permit the introduction of the fingers behind the articulations. By incisions made by a succession of slight cuts from above by a bistoury, while the organs behind the symphysis were protected from injury by the finger placed between them and the bone, the disarticulation was completed, and a separation with a cracking sound resulted, as the limbs were slightly opened out, to the extent of two or three fingers' breadth. Hæmorrhage was slight and easily controlled by pressure. The child was then easily delivered alive by the forceps. The wound of the soft parts and of the bones was sutured in the usual way and bandaged, and the woman sat up on the twentieth day, and was finally discharged cured.—*Annales de Gynécologie et d'Obstétrique*, 1892.

CRANIOTOMY AND CÆSARIAN SECTION.—Bársony disapproves of leaving the choice between the operations to the mother. During pregnancy the choice is between premature labor and Cæsarian section. During labor the mother is too much influenced by pain to judge properly. It is better to act on the judgment of the physician. The Cæsarian section belongs properly among hospital operations while craniotomy admits of a broader range and need not be restricted to hospitals. The preparations for an aseptic laparotomy cannot be so perfect in a dwelling as in a hospital, and the result to the mother is so much the more unfavorable, the longer labor has been in progress. Säger is wrong in anticipating the same extension in general practice for Cæsarian section as for craniotomy. Bársony agrees with Winckel that when young physicians hasten to perform Cæsarian section, the old mortality of eighty per cent. will be reached.

The most recent statistics of Cæsarian section show a mortality of 8.6 per cent. and of no deaths from craniotomy (Dresden Clinic).—*Centralblatt für Gynækologie*, No. 47, 1892.

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY
CHAS. M. THOMAS, M.D.

TREATMENT OF THE NOSE AND THROAT AS A SOURCE OF MIDDLE-EAR DISEASE.—PRECAUTIONARY SUGGESTIONS.—Thomas Barr, M.D., of Glasgow, considers (*London Lancet*, December 17, 1892), the risks attending the use of irrigations to the nose, such as Weber's douche, the syringe and simple sniffing. Structural peculiarities in the nasal passages and Eustachian tube, existing naturally or induced by disease, are probably the most important factors favoring the entrance of liquid into the middle-ear during the use of the syringe or douche. Of these structural peculiarities, however, the partial or complete impermeability of one or the other nasal passage, or of the cavity of the naso-pharynx, is the most fruitful source of accident. Such impermeability is common, and may be due to deflection, exostosis or enchondrosis of the septum, to hypertrophic or other swelling of the turbinated bodies, or to post-nasal growths. When one of the nasal passages is thus closed and liquid is injected into the opposite nasal passage by a syringe, the nozzle of which fits tightly into the orifice of the nose, a passage of liquid into the middle-ear will be an almost certain result. It is to be carefully noted that in any case, even when no structural peculiarity exists, and when the syringe is used with every precaution, *the performance of the act of swallowing during the passage of the fluid through the nasal passages greatly favors the entrance of the liquid into the middle-ear.* Another danger is that the liquid remaining in the crevices of the naso-pharynx, shortly after the injection, is often impelled into the middle-ear if the patient blows the nose vehemently or sneezes. The habit of drawing or sniffing cold water into the nasal passages, indulged in by some persons with the idea of curing or preventing cold in the head, is probably responsible for a number of middle-ear inflammations.

Dr. Barr then gave the following precautionary suggestions in order to avoid or diminish the risk of exciting disease in the middle-ear when treating the nasal passages and naso-pharynx: 1. Patients, before using the nasal syringe, Weber's douche, or the hand-douche, should be carefully instructed by the surgeon in their proper and safe use. 2. Previous to injecting fluids by the syringe or Weber's douche into the nose, or prescribing such, the nasal passages should be carefully examined, and if one should be found obstructed the fluid should be injected *into the obstructed passage.* 3. The nozzle of the syringe should not tightly close the nostril, and during the injection of the fluid the stream should be frequently interrupted. 4. If a syringe is employed, too great force must not be used, especially if there be resistance to the flow of the fluid from one nostril to the other; if Weber's douche is employed the fall must not be too great, not more than two feet. 5. The fluid injected should always be comfortably warmed—say 80° to 90° F.—and it should hold in solution a saline, such as a 1 per cent. solution of common salt or bicarbonate of soda, while in œzema and other bacterial diseases a definite antiseptic should be employed. 6. The act of swallowing must be carefully avoided during the douche; this is aided by breathing through the mouth. Eitelberg suggests that the patient should protrude the tongue so as effectually to prevent the act of swallowing. 7. In the case of infants or very young children, or in adults whose Eustachian tubes are abnormally permeable, the syringe or Weber's douche should not be employed. The liquid in these cases should be poured into the nasal passages with a spoon or other suitable appliance, while the patient (if old enough) should sound the vowel "a." 8. The patient should not blow his nose, nor, if possible, sneeze, for at least fifteen minutes after; he should be instructed that in the event of the liquid entering the ear, he must swallow several times with the nostrils closed. 9. After operations on the nose or naso-pharynx, or the use of corrosive substances which may produce swelling or obstruction, the syringe should be avoided or used with great caution for a few days, during which the patient should be careful to avoid exposure to cold or septic influences. 10. In operations or cauterization great care should be taken to insure cleanliness and an aseptic condition of the instruments or appliances used. If the finger-nail is employed to scrape away vegetations there is obviously special need for precautions in these directions.

A LEECH IN THE LARYNX.—Dr. Aubert, of Algiers, in a communication to the Laryngological Society of Paris, recounts a case in which a woman of 57 years

had swallowed a microscopic leech in a glass of water. It was only after a week of suffering from asphyxia and hæmoptysis that it was dislodged, which happened in this way: Dr. Aubert was making a laryngological examination when the leech got into the larynx, necessitating tracheotomy. During its stay in the throat the annelid had attained the volume of a pencil.—*Jour. de Med. de Bordeaux*.

SPASM OF THE LARYNX.—In an article on the trembling of the vocal bands and the disorders of phonation in disseminating sclerosis of the spinal cord, M. J. Collet, of Lyon, reports an instance in Garel's clinical service, and presents a summary of the similar cases previously reported, and makes some general observations. He sums up the functional disorders of the laryngeal muscles into a monotonous and scanning voice, brusque change of tone, elevation of pitch, impossibility to maintain the same note for a long time, stridulous inspiration interrupting laughter or weeping, paralysis of some of the muscles of the larynx, and, finally, the tremulousness of the vocal bands. These phenomena may be combined, or exist isolated, or succeed each other, as in the case related.

Under the heading, "A Case of So-called Laryngeal Vertigo," Dr. L. Adler, of New York, reports a case in which spasmodic cough frequently produced sudden loss of consciousness without vertigo, and which was cured by clipping an elongated uvula. Quite a full summary of the literature of laryngeal vertigo follows the description of the case, which occurred in a gouty man 53 years of age. Attention is directed to the circumstance that in all the recorded cases except one the patients have been males, most of whom had passed their fortieth year before their first attacks.

Oppenheim reports a case in which there was a tumor the size of an egg in the cerebellum, with marked flattening of the pons and of the medulla oblongata. The roots of the vagus and of the accessorius were very hyperæmic, with numerous bleedings and a well-advanced atrophy. During life there had been trembling of the head and of the upper extremities on voluntary movements only. But there had been a continuous rhythmic tremor of the soft palate, as well as of the outer and inner musculature of the larynx.

The larynx was continuously drawn up and lowered. The rhythmic contraction of the crico thyroid muscle could be felt externally, and on laryngoscopic inspection continuous tremblings (*Zuckungen*) of the inner laryngeal muscles and the movements of the arytenoid cartilages could be seen. These manifestations, which produced disturbances in deglutition, as well as in speech and voice, had been observed in varying intensity for a period of about two months.—*Neurologische Centralblatt*, 1892, No. 5.

PRIMARY LARYNGEAL ERYSIPELAS.—Dr. Oscar Samter reports the following case: without there being any signs of disease in the mouth or throat, there appeared suddenly, beginning with a chill, in a middle-aged man, an acute, superficially extending laryngitis. Although the larynx was extraordinarily roomy, in twenty-four hours tracheotomy was necessary. Twenty-four hours later there appeared, without another chill, spreading from the tracheotomy wound, a rapidly extending erysipelas of the skin. These facts point with the greatest probability to this being a case of primary laryngeal erysipelas, from which the erysipelas of the skin extended. These are rare cases. The infection may be carried by the air or by food to microscopic defects in the mucous membrane.—*Deutsche Med. Wochenschrift*.

TOXICOLOGY OF MALE FERN WITH SPECIAL REFERENCE TO VISUAL DISTURBANCE.—Drs. K. Katayania and I. Okamoto have studied the reported cases of poisoning, more than twenty in number, which have occurred since in 1881, and find that ten of these presented notable visual disturbances, five of these having occurred in Japan. Coincident with the increasing frequency of these cases has been the gradual raising of dosage, it being the general opinion of physicians that it was a harmless as well as an efficacious drug. From experiments, they conclude that it acts particularly upon the digestive system and nerve centres; that failure of vision occurs chiefly in persons poor in health (*cf.* alcohol or tobacco amaurosis). Practitioners should note: 1. That extract of male fern is best prescribed in small doses. 2. Such symptoms as headache, amblyopia, should be watched for, and with their appearance the further use of the medicine stopped.—*Sei-i-Kwai Medical Journal*, No. 6, 1892.

MONTHLY RETROSPECT OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D., AND FRANK H. PRITCHARD, M.D.

A HOMŒOPATH IN THE HAMBURG EPIDEMIC OF CHOLERA.—Mr. A. Paasch, of Hamburg, not a physician, but a layman who is versed in homœopathy, relates an interesting experience with the cholera, in the recent epidemic of that disease in Hamburg. As the epidemic progressed, the number of physicians was unequal to the call for aid, and educated laymen were called upon. He announced himself, and was assigned to a place as assistant to a district physician. Camphora was first given, without result. On carefully studying the symptoms, arsenicum was chosen as the epidemic remedy, and the choice proved to be a good one. Arsenic was also the epidemic remedy of the visitation of 1837, as Vehsemeyer reports. He began with the remedy in the sixth dilution, but only succeeded in the first stage, where there were pressure in the stomach, anguish, vertigo, great thirst, weariness, etc.; yet, in the graver cases, the symptoms were those of arsenic—being the above, with the addition of great restlessness, especially worse of nights; watery vomiting, renewed after drinking the slightest quantity of cold water; watery stools; dark-bluish rings around the eyes, the eyelids falling away from the eyeballs, and not covering the globe; cramps in the calves of the legs; facies hippocratica, and ice-cold and bluish extremities. As he descended to the fourth and third triturations (dec.), he found that he could save the patients when they had reached the second stage. In order to prevent the radiation of heat, which was progressing too rapidly from the disease itself, instead of cold drinks and cold applications, as the allopaths prescribed, he ordered warm and moist applications to the abdomen and chest, hot stones or bottles to the feet, while the patient was covered up to his neck with the bed-clothes (for the cholera-patient constantly throws his arms out upon the bed-coverings in his anguish). The cold limbs are rubbed with a solution of camphor in alcohol. The patient was not allowed to arise from his bed to pass his stool, but passed it in bed into clothes that, when soiled, were simply replaced by warm ones. In order to assist the rapid outbreak of perspiration, a cup of strong coffee was given with the best results. When the patient was in an advanced stage, a very low dose of arsenic would produce a wonderful change; for example, in cases where there was complete loss of voice, great dyspnoea, asphyxia, retention of urine, the extremities icy-cold and blue, terrific cramps in the legs and chest. The writer has snatched a number of such cases from certain death by the administration of a very low dose of arsenic. Cuprum was of value, when there was abdominal gurgling; the drinks could be heard to gurgle down the œsophagus; spasms, beginning in the fingers and toes, opisthotonus, and boring the head into the pillow. Sulphur was also indicated in a few cases, together with the arsenicum, when the diarrhoea would drive the patient out of bed at five in the morning, or where the patient was of a lymphatic constitution. Secale was also administered in connection with arsenic, when there was formication in the fingers and toes, with spasmodic spreading of the fingers, and when ejection of a watery vomit was present, which passed over into bloody vomiting. In none of the cases were the symptoms to be interpreted as indicating any other remedy than arsenic. Only in one case did veratrum album seem indicated, on account of the cold-sweat on the forehead, but it produced no improvement and had to yield to arsenic. He found that patients must be very careful not to leave the bed too soon, as it will surely bring on a relapse. Great care is to be used in eating and drinking after an attack.

The most rapidly coursing form was that known as cholera sicca. Here, there are neither diarrhoea nor vomiting, but merely great anxiety, terrific pain in the chest,

and death in from one to three hours. These patients are chiefly found speechless, asphyxiated, and gasping for breath. Two of such cases were saved, by the administration of arsenic in one case, and arsenic and carbo vegetabilis in alternation in the other. All the others under his care died, for no reaction followed the indicated remedy. In one such case he was accused by the allopathic physician of poisoning the patient by arsenic, and being the cause of his death, though the physician himself had said that the case was hopeless before the writer had seen it. From a record of his cases, he deduces a death-rate of 5 per cent. in the cases of the second and third stage, excluding the slight ones.—*Leipziger Populäre Zeitschrift fuer Homœopathie*, Nos. 23 and 24, 1892.

A CASE OF NEPHRITIS CURED BY ARSENICUM.—Dr. Paul Lutze, of Koethen, Germany, was called to a patient, a farm-laborer, 38 years of age, who had been very sick for ten weeks. He had been treated allopathically all this time without results. He was found to be greatly œdematous over his whole body, and unable to move in the least. Examination of the urine revealed albumin to be present, $\frac{1}{4}$ -volume. Arsenicum 30 was given for ten days without change. This potency was continued for ten days longer without any results. Then the fifth decimal was administered every two hours, and, in three days, a change had taken place for the better. Though the legs were increased in size, the swelling in the arms and body was smaller. Five days after all the symptoms were improved, and the albumin was present only $\frac{1}{8}$ -part, by volume. The patient was found stirring around the yard, and his appetite had manifested itself. Eight days after, there was but a slight swelling around the ankles, which increased somewhat in the evening, while the quantity of albumin had greatly diminished, so that but an opal-colored reaction was to be seen twenty-eight days after the administration of the remedy in the third decimal trituration. Nine days after this, the albumin had completely disappeared from the urine, the œdema entirely gone, the patient had a good appetite and increased in strength and health. Yet he was still somewhat easily exhausted, and did not resume his heavy work for several days after.—*Allgemeine Homœopathische Zeitung*, Nos. 21 and 22, 1892.

LOBELIA INFL. IN NAUSEA OF PREGNANCY.—About the first of last March a lady came to me with the following condition: "Am sick at my stomach every morning; I get dizzy, and when I am worse break out in a sweat on my hands and face. The only thing which helps is to drink something every little while, it matters not whether the drink be hot or cold." I gave *lob.* 6 every four hours, and next saw her on June 26th, when I delivered her. She then told me that she was relieved in twenty-four and cured (without a return) in forty-eight hours. The symptoms in Allen's *Hand-Book*, which I thought covered the above case, are: "Nausea all the morning; in the morning < by a swallow of water; with vertigo; with cold sweat on head, > face."—George Royal, M.D., in the *North American Journal of Homœopathy*, October, 1892.

PLATINUM MURIATICUM IN UTERO-OVARIAN NEURALGIA.—Miss C., æt. 24, nervous temperament. For several years, at periods varying from three to six or more weeks, has had extreme sexual desire, which she would not gratify. After a few days (over two or three, as desire lasted), she would have attacks of excruciating pain in the umbilical and lumbar regions, continuing for hours, for which her allopathic physicians had given hypodermic injections of morphine as the only relief. She could not accurately describe the seat of the pains, but the facts stated by her warranted my considering it a neuralgia of the internal genital organs. She had given up all hopes of being cured so long as she remained single. She received six powders of *plat. mur.* 3x, one to be dissolved in fifteen teaspoonfuls of water—a teaspoonful every three hours at first, then, if improvement began, at longer intervals. Before she had taken it a week improvement was noticed in decreased sexual desire. She had two more prescriptions of the same medicine and was cured, never having an attack of the pain after beginning treatment. Her habits and work were as they had been from the beginning of the attacks, and she took no other medicine. So far as I know, there has been no return of the trouble for the three years which have elapsed.—W. Scott Hill, M.D., in the *North American Journal of Homœopathy*, October, 1892.

PSORINUM FOR OTORRHOEA.—Man, æt. 22. Otorrhœa for a number of years; had been treated by allopathic and homœopathic physicians with slight relief.

When he consulted me the discharge was very offensive and excoriating. *Psorinum* 30 was prescribed, and in one week the discharge stopped, and there has been no return for a year. With this remedy, a little dry powdered boric acid was blown into the external ear once a day. The cure was brought about by the *psorinum*, as the local application had been used before with negative results.—Dr. George M. Ockford, in the *North American Journal of Homœopathy*, November, 1892.

SEPIA FOR MENSTRUAL HEADACHE.—Woman, dark complexion, æt. 49; had always suffered with menstrual headaches, either before or after the flow. Menstrual functions still regular and no signs of the climacteric. *Sepia* 200, one dose taken when headache is coming on always relieves it.—Dr. George M. Ockford, in the *North American Journal of Homœopathy*, November, 1892.

ZINC FOR NERVOUS RESTLESSNESS IN PREGNANCY.—A woman, in the seventh month of pregnancy, was unable to sleep on account of nervous restlessness; she could not keep her feet still. *Zincum* 12 gave immediate relief.—Dr. George M. Ockford, in the *North American Journal of Homœopathy*, November, 1892.

REMEDIES IN SYNOVITIS.—In a study of a case of synovitis, Dr. Chas. H. Thomas, of Baltimore, presents the following review of the remedies usually indicated in such cases: *Apis* gives a perfect picture of synovitis of the knee; the pains where it is indicated are sharp, lancinating, stinging, shooting through the joint, aggravation from motion, and better from cold application.

Bryonia also acts well on the joints and synovial membranes: the pains are aggravated from motion, stitching with tension, better from warmth.

Iodine is also useful in some cases, especially in scrofulous individuals.

The *iodide of potassium* is indicated when the trouble results from syphilis.

Pulsatilla is indicated in gonorrhœal, rheumatic, and gouty affections of the joints, also in traumatic synovitis; the pains are of a sharp, stinging character; there is a feeling of soreness similar to that of abscess just before suppuration. The pains usually shift from one part to another; the tearing pains force the patient to move the affected limb which gives temporary relief, and the pains are worse in the evening, and from warmth, being relieved from cold.

Sulphur is useful in some cases that refuse to respond to the well chosen remedy.—*Southern Journal of Homœopathy*, November, 1892.

PROVING AND VERIFICATION OF CADMIUM IODIDE.—In 1887 Dr. F. O. Pease prepared the 6x potency of this salt, and during the day took six doses. About the only symptoms elicited were a troublesome itching of the rectum and anus; which began about the fifth day of the proving; associated with this was a constipation that proved to be obstinate and troublesome. There was frequent desire for stool without result, or only scanty discharge of dark brown offensive stools, clay-like in consistency, and while at stool an almost irresistible desire to strain forcibly so as to push downward or prolapse the rectum for the relief to the itching. This itching was during the day only, and worse when walking or heated; began about 9 A.M. followed in a few minutes by desire for stool, and the attempt was sure to greatly aggravate the itching, while at the same time the efforts at straining seemed to relieve or were very agreeable, as also better from pressing on the partially prolapsed rectum while thus straining. There was during the afternoon much bloating of the abdomen with sensation of fulness and relief from passage of flatus. This itching torture became so unbearable, and the desire to remain at stool so inconvenient that remedies were taken but with little benefit. During the second week it slowly subsided. It was a long while before the bowels regained their former regularity.

In 1889 Dr. Pease cured a case of itching piles in a carpenter 63 years of age. He had long suffered from constipation. The case was characterized by much flatulence, which on passing started up a troublesome itching, which increased until he must go to stool; also there was aggravation of the itching when overheated or when walking. While at stool the peculiarities of the above proving were closely imitated. Several powders of cadmium 6x were given. The whole condition was cured. Several cases of itching anus have been benefited if not cured by this remedy alone.—*The Homœopathic Physician*, November, 1892.

GYMNOCLADUS IN INFLAMMATORY CONDITIONS OF THE STOMACH.—Dr. F. O. Pease calls attention to gymnocladus in inflammatory conditions of the stomach.

He has found it of value in a few cases where there was one or more of this group of symptoms; loud belching, eructations of food some time after eating, also eructations of intensely sour water after eating, or when the vomiting comes on. As characteristic, "burning in a small round spot in the stomach, worse after eating, but continuous.—*Homœopathic Physician*, November, 1892.

TREATMENT OF PERICARDITIS.—Dr. P. Jousset recapitulates the treatment as follows: At the beginning of the disease and in its acute form the principal remedies are aconitum, cannabis, spigelia, colchicum, cantharis, apium virus and arsenicum.

Aconitum.—This remedy has been praised by all homœopaths in the beginning of the disease. It suits the febrile movement, the præcordial pain, the palpitation with anxiety, the full and accelerated pulse which is afterwards weak and irregular, the tendency to fainting so frequent in pericarditis.

Dose.—Twenty drops of the mother tincture in 200 grammes (6½ ounces) of water, and of this a spoonful every two hours.

Cannabis.—This remedy is especially recommended by Hartmann after aconite. Its pathogenesis presents palpitation, with anxiety and violent lancinating pains in the præcordial region.

Dose.—The first three dilutions or even the mother tincture.

Spigelia.—This is the remedy which is chiefly recommended by Richard Hughes and the English homœopaths. Palpitation, small, irregular pulse, and a tendency to syncope are produced by spigelia. But it is of especial value when the symptoms of dysphagia and angina pectoris indicate a propagation of the pericardial inflammation to the phrenic nerves and the cardiac plexus.

Dose.—The first three dilutions and even a few drops of the mother tincture.

Colchicum.—This drug is chiefly indicated by clinical experience and by its efficacy in the treatment of rheumatismal endocarditis. Drs. Kidd and Laurie have found it of great service in rheumatismal pericarditis. At a more advanced period of this disease when the fever has fallen, arsenicum, cantharis, apium virus, and plumbum are indicated to produce an absorption of the effusion.

Arsenicum.—Constrictive pain at the upper part of the sternum, violent and irregular palpitation, nocturnal anxiety and especially a tendency to fainting indicate this drug. The first six triturations repeated four times a day.

Apium Virus and Cantharis.—These two remedies are indicated on account of their favorable action in pleurisy. A certain degree of œdema which is especially found in chronic pericarditis, is indicative of apium virus. The dose is the same as in pleurisy.

Puncture of the pericardium has been practiced in some cases where the effusion was considerable and suffocation was imminent.—*L'Art Medical*, No. II., 1892.

COLOCYNTHIS IN DIARRHŒA.—Dr. Goullon treated an elderly lady who was habitually short of breath, melancholic and inclined to rheumatic and catarrhal affections. She had contracted by exposure to cold a slight diarrhœa, with frequent evacuations, continual tenesmus, slight burning, rolling and painful sensitiveness of the left side. This latter symptom had been present since she had had the influenza. In spite of carefulness in diet she retained an inclination to diarrhœa. When lying quietly in bed she suffers nothing. She sweats of mornings, quite profusely. As soon as she leaves the bed she is attacked with diarrhœa, rolling in and sensitiveness in the left side, etc. Colocynthis, 6, was given, and a dose taken every three hours. A few days after she reported herself as relieved.—*Leipziger Populäre Zeitschrift fuer Homœopathie*, Nos. 21 and 22, 1892.

NATRUM MURIATICUM IN ECZEMA IMPETIGINOSUM.—Dr. H. Billig, of Leipsic, was consulted by a pensioned baggage master of a Saxon railroad on account of a long lasting and very obstinate eczema of the hairy scalp. He was 67 years of age, and had always been troubled with eruptions, pustules and tinea capitis. His parents were healthy, and his sisters and brothers had been troubled but little with cutaneous eruptions. While in the military service he had had an eczematous eruption on the thighs which had been dried up by means of a zinc salve. This had bothered him, off and on, for a long term of years, until 1889 when the disease broke out with renewed vigor. The entire scalp was wholly hairless, reddened and inflamed, and shining from the free secretion, which continually oozed through, so that the surface was always necessarily covered with cloths. The upper and lower extremities were also covered with eczematous spots. Even if a spot would

become covered with a crust the secretion would keep up under the covering until it was accidentally removed, white and shining. The patient was discouraged. Several remedies were given, chiefly antipsorics, with negative results. Finally, *natrum muriaticum*, 3x, was prescribed, a small powder every morning, in half a cup of warm water and taken on an empty stomach. This was continued for two and a half months, with good results, for the exanthem had yielded, the exudation was less, the excessive and shining red of the skin had decreased, and here and there the scalp had taken on a normal appearance. The remedy was repeated for two months more, when, at the last visit the scalp was completely clean, the exanthem had disappeared entirely, his hair had returned, but instead of the former white it was of a dark-brown. The former depression and low spirits had made way for a joyful and happy condition of mind which was very grateful to the formerly tortured patient.—*Allgemeine Homœopathische Zeitung*, Nos. 17 and 18, 1892.

TREATMENT OF AORTITIS.—Dr. P. Jousset, of Paris, states aortitis to be an extremely rare affection, and one which was not known until the works of Bazot and J. P. Tessier on its symptomatology, and Virchow on its pathological anatomy, made their appearance. The principal remedy is *aconitum*, then follow *apis mellifica* and *tuberculinum*.

Aconitum.—This is the remedy to be given in the beginning. It is indicated by the violence of the febrile movement, agitation, with anxiety and sternal pain. It should be prescribed in the mother tincture—twenty to forty drops in a glass of water, and of this a spoonful every two hours.

Apis Mellifica.—This drug should replace aconite when anasarca becomes very pronounced. It also covers the albuminuria. The first three triturations, in the same manner as aconite.

Tuberculinum.—Tuberculine, Koch's lymph, has not yet been employed in acute aortitis, but the author recommends it on account of its producing an inflammation of the heart and aorta. Use from the third to the sixth dilution.

TREATMENT OF CHRONIC AORTITIS—This subject has been fully treated of under the heading of vascular endocarditis, which condition is usually, to-day, described as chronic aortitis. The iodides of sodium and potassium, as well as the arseniate of antimony, constitute the three principal remedies in the treatment of the chronic form.

TREATMENT OF ANEURISM OF THE AORTA.—In order to understand the treatment of aortic aneurism it must be remembered that this lesion is due to the presence of a chronic aortitis, of which it is one of the terminations. The iodides of sodium and potassium are hence the two principal remedial agents in the treatment of this lesion. They are to be given in the doses indicated in the treatment of vascular cardiopathies. Pouillet, Balfour, and Huchard, have insisted upon the importance of treating aortic aneurism by means of the iodides of sodium and potassium. Besides these drugs, one may also consult *lachesis*, *lycopodium*, and *pulsatilla*.

Lachesis.—The symptoms indicating this drug are: A sharp and anxious pain, with a sensation of considerable pressure behind the sternum; palpitation, dyspnoea, spells of pulselessness; pulse weak and irregular; symptoms of paralysis of the vocal cords. Employ the sixth dilution, twice a day, for several weeks.

Lycopodium.—This drug counts a certain number of clinical successes. It is recommended by Roth and Richard Hughes, not only in aneurisms of the aorta but also in those of the carotids and external iliacs. Administer from the twelfth to the thirtieth dilution.

Pulsatilla.—This drug has been prescribed in aneurism of the aorta without any well-authenticated case being able to be found. The pathogenesis of this drug only furnishes us with a few vague symptoms—palpitation, dyspnoea, harassing cough on lying down, choking sensation accompanied by a feeling of constriction in the trachea. Give from the mother tincture to the sixth dilution.

[Dr. W. E. Gill, of Norwalk, Ohio, claims that, several years ago, he treated a case of undoubted aneurism of the aorta with success by the internal administration of this very drug, *pulsatilla*. The patient, a medical student, had been examined by several distinguished members of the homœopathic profession, and his case pronounced hopeless. He was sent home to die, and prepared for the final termination. As he also wore a compressing band with a pad, all credit cannot be ascribed to the drug.—ED.]

CHRONIC, GENERAL TUBERCULOSIS, APYRITIC, OF INFANTS AND CHILDREN.—Dr. Marfan claims this to be the most common form of tuberculosis in infants and children. Though very common, it has not been well isolated and studied until quite lately. There are three signs of diagnostic importance, namely, the presence of small, hard, movable, and indolent lymphatic glands in the cervical, inguinal, and axillary regions. They are of varying size, and impress one as if grains of lead were under the skin. Secondly, a hypertrophy of the spleen and liver, and, thirdly, cachexia. The appetite is voracious (bulimia), yet the food is seemingly not assimilated. It is observed in children under five years; after this age it is rare. From fifteen months to three years is the time when it is especially seen. It begins often with a febrile bronchitis or a broncho-pneumonia, either spontaneously or following the measles, whooping cough, or the grippe. As soon as the bacillary infection develops the fever falls, and the child remains cachectic for a few months to a year. A slight febrile diarrhoea may be the point of departure, or it may commence insidiously. The lymphatic system is the first point of attack. The cachexia is characteristic. The patient is emaciated; its limbs small and withered; its skin is pale; its eyebrows long and black, and often, on the back and limbs, there is a precocious development of hair—*puer pilosus*, *puer tabidus*; its face is drawn and fatigued; its eyes are surrounded with rings, yet they are sometimes lively and animated. The physiognomy is of diagnostic importance, though it by no means resembles that of a scrofulous child. The liver as well as the spleen may be enlarged. The presence of the enlarged glands is of importance as long as it is not due to excoriations of the skin or syphilis. The disease is feverless, except at the beginning and at the end. Thoracic examination reveals, as a rule, tracheo-bronchic adenopathy. Bronchitis is now and then present, and a relapsing bronchitis should always lead one to suspect tuberculosis. Here and there spots of dullness will be found all over the lungs, for in children tuberculous infiltration is not limited to the apex. The general condition more or less slowly aggravates, and death may take place slowly and without pain, from continuous tuberculous poisoning, without any organ being profoundly affected. This is not always the case, for death may be produced by a suddenly-appearing meningitis, a broncho-pneumonic attack, or from rapid increase in size of the tracheo-bronchial glands. The fatal termination may be hastened by a secondary infection, by streptococci or pneumococci, with fever, etc. The necropsy reveals tuberculous alterations of various degrees—caseous, miliary, and yellow tubercles. The prognosis is nearly always inexorable. As to the diagnosis, it cannot be made from the condition of the lungs. It is not to be confounded with:

1. *The cachexia of rachitism*, easily decided from examination of the bones.
2. *Gastro-intestinal cachexia*, with predominance of gastric and intestinal disturbances; vomiting; green, yellow, or whitish dejections, the child having a dry skin and the aspect of an old man.
3. *Certain relapsing broncho-pneumonias*, with great emaciation, for when the broncho-pneumonia is not tuberculous there are no enlarged glands, no enlarged liver or spleen, nor bulimia.
4. *Syphilitic cachexia*, in certain cases, is difficult to distinguish, as it may be associated with hypertrophic spleen, liver, and poly-adenopathy, though this latter sign is very rare. Syphilis is accompanied by cutaneous eruptions on the buttocks, the posterior portions of the thighs, the legs, around the mouth, behind the ears, on the forehead, and around the eyebrows; by lesions of the mucous membranes, as fissures of the mouth, chronic coryza, and by cranial osteophytes. The syphilitic infant has a different physiognomy; it is but slightly emaciated, has a yellowish complexion, the eyebrows are lacking, and the hair is scanty. Examine the child's parents.
5. *The cachexia of inanition* is recognized by integrity of all the organs and functions, while there is a history of a premature birth or of insufficient nourishment.—*La Semaine Médicale*, No. 64, 1892.

MEASLES WITH A HÆMORRHAGIC DIATHESIS.—Dr. Lanche, of Christiania, Norway, describes a case of measles in a 22-year old woman, which was complicated by hæmorrhages from the nostrils, intestines, kidneys, and with the appearance of petechiæ upon the whole body, and especially the abdomen. She recovered. The prognosis varies greatly. In some cases it is of no great importance, while in others it may be followed by rapid death.—*Norsk Magazin for Lægevidenskaben*, No. 10, 1892.

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ERASION OF THE KNEE-JOINT VS. RESECTION.

BY HORACE PACKARD, M.D., BOSTON.

THE knee-joint is especially liable to tubercular inflammation, and too often this inflammation goes on to such widespread and extensive destruction of the articular cartilages and adjacent soft and bony tissues, that something in the way of operative measures becomes necessary. I have many times made resection of the knee-joint, but always with the feeling that the magnitude of the operation has been disproportionate to the gravity of the disease. The shortening by this method is also always considerable. My results after resection have invariably been good, with firm union and a serviceable leg. I have been much interested in the literature of erosion of the knee-joint, and at the beginning of the year just past decided to try it on such cases as I might otherwise perform resection.

While one successful case does not establish the value of a method of treatment, yet the excellent results here obtained, coupled with the flattering reports from other sources,* lead me to believe that in many cases, perhaps not all, by any means, it may give better results than resection.

The question may be asked: "What is erosion of the knee-joint?" and "To what cases is it especially applicable?"

Erosion is the scraping away from the knee-joint, after it has been

* *On Erosion or Arthrectomy of the Knee-Joint*, by G. A. Wright, F.R.C.S., and Joseph Collier, F.R.C.S., of Manchester, England.

exposed and the articular surfaces brought fully into view, of all the diseased or infiltrated tissue on or about the articular surfaces, and, if any tubercular foci have penetrated the bone, to thoroughly scrape and clear away until sound bone is reached, and, in addition to this, the cutting away with the scissors of all the infiltrated soft parts in the vicinity of the joint. It is especially applicable to those cases where the disease has not progressed much beyond the articular cartilages and ligaments. The special advantages of the operation are:

1. There is no shortening.
2. There is no deformity beyond the ankylosis of the joint.
3. There is no arrest of growth in children, because the bone not being specially interfered with, the epiphyses which provide for future lengthening of the limb are not retarded in their development.
4. Free movement in the joint has resulted, though it is not to be expected or aimed at.
5. The operation is much less in severity, with correspondingly rapid convalescence.

The two principal conditions upon which the success of this operation depends, seem to be thorough removal of diseased tissue and most rigid antisepsis.

CASE.—Miss B., a working-girl, had a gradually-increasing swelling and pain of the right knee.

It was at first thought to be rheumatism, but, as time went on, and exquisite sensitiveness developed and persisted in spite of all treatment, with a continued high temperature (102° F.), no doubt was left in my mind that the case was one of tubercular arthritis.

I freely opened the joint by a transverse incision below the patella and exposed the articular surfaces, which were already of a dirty-grayish color. The diseased articular cartilage was all cleanly scraped away with a strong curette, and all infected synovial tissue trimmed away with the scissors. The crucial ligaments were not disturbed. The wound was closed and the leg placed in a fixation splint.

From that time on the patient was entirely free from pain or discomfort of any kind in the limb. Healing took place rapidly, the temperature dropped to normal, and appetite quickly returned.

In six weeks there was complete ankylosis, and with a posterior supporting splint the patient was allowed to go about on crutches.

At the present time, one year from the date of the operation, the patient is in perfect health, with a strong serviceable limb, upon which she walks with scarcely a noticeable limp.

THE USE OF ATROPINE IN DISEASES OF THE EYE.

By CHARLES M. THOMAS, M.D. *(H. M. S.) called attention to*

(Read before the Homœopathic Medical Society of the County of Philadelphia,
January 12, 1893.)

IN the practice of every ophthalmologist cases ^{where} not infrequently come to his notice where most unfortunate results have arisen either from the failure to employ mydriatics, of which the sulphate of atropine stands as the type, or, from their exhibition under circumstances where they are positively contra-indicated. It would seem at first thought that the indication for so time-honored a remedy could hardly be other than thoroughly appreciated by the profession generally, but experience certainly does not seem to show this to be the case. Either they are not sufficiently well known, or there exists among us an unaccountable indifference or carelessness in the application of the indications. I have, for instance, not long ago, been consulted by a patient whose vision had been almost entirely lost by obliteration and occlusion of the pupil by plastic deposit, the result of repeated attacks of iritis, in which no attempt had been made to preserve the freedom of the iris and pupil by the use of mydriatics, on the ground that the employment of such poisonous agents was never justifiable. During the past fall a number of cases have come under my notice where the sight has been partially or wholly lost by a glaucoma, that has either been precipitated or greatly intensified by the use of atropine, under the impression that the disease was one of iritis, or where the character of the affection was unrecognized, and the remedy applied haphazard.

These harmful results, appear to me to arise at the hands of two classes—first, those of our physicians, few in number, fortunately, who do not use atropine at all, who are opposed to its use on principle, believing that it can only do harm; or, again, those who simply overlook it, through the vagueness of their knowledge and appreciation of its value. Secondly, those who do employ it, but in an indiscriminate, sort of happy-go-lucky fashion, that is, in doubt, perhaps as to the exact nature of the disease before them, or as to what more should be done for it, they feel that they will put themselves on the safe side, so to speak, by placing the eye under the influence of the ophthalmic cure-all, atropine. While the sins of

omission in this matter are certainly not inconsiderable, those of commission are perhaps even greater.

Before speaking of the conditions calling for the use and the avoidance of atropine it may perhaps not be amiss to briefly touch upon the manner of its employment in ophthalmic practice. In the first place I probably need not remind you that its action when applied to the front of the eyeball (cornea) is entirely a local one and not brought about through introduction into the general circulation. Its absorption through the cornea is followed in a few minutes by dilatation of the pupil and abolition of the power of accommodation. Its full effect in uninflamed eyes, lasts two or three days, and gradually decreases till lost in ten to fifteen days. Whether in addition to the mydriasis the alkaloid has any influence in altering the tension of healthy eyes is still doubtful, but that it does materially raise the intra-ocular tension where a tendency to this state exists, is beyond all doubt.

The strength ordinarily used is about four grains to the ounce; frequently a smaller, and occasionally a much larger quantity of the drug is employed. The solution is best dropped directly upon the cornea, and instillation may be repeated every few hours, or rarely, for a limited time, to get a very prompt and energetic action, every few minutes, as will be seen in the treatment of iritis.

A condition of general intoxication may be set up, only through entrance of the solution by the lachrymal passages to the nose and throat mucous membrane and absorption thence into the general circulation. While the weaker preparations do not ordinarily cause disturbing symptoms, the precaution, particularly in using the stronger solutions, should always be taken to prevent the passage of the tears into the nose, by drawing the lid with its punctum away from the ball, and by pressure within the inner canthus with a firm pellet of absorbent cotton which will at the same time take up the superfluous fluids.

The conditions calling for the employment of atropine are found :

1. In the treatment of a large variety of inflammatory affections and injuries, more particularly of the iris and cornea.
2. As an aid in the examination of the structures lying behind the plane of the iris.
3. As a means of placing the accommodation at rest in the estimation of errors of refraction.

To the general practitioner the most important application of atropine will be found in the management of the inflammatory ocu-

lar diseases and traumatisms. Its beneficent action is most typically witnessed in the treatment of inflammations of the iris; more particularly in the plastic forms of iritis its importance can hardly be overrated. In strongly contracting the radiating muscular fibres it acts antiphlogistically in lessening the calibre of the vessels and so diminishing engorgement of the parts. Again, it is found most effective in controlling pain, both on account of its known anæsthetic properties and through its action in controlling the motion of the iris and ciliary body thus placing these inflamed parts in splints, as it were. While iritis is not always a painful disease, yet a large proportion of cases is attended by much, and sometimes intense suffering both in the eye and head, which in most instances is greatly mitigated if not entirely relieved so soon as the iris is well dilated. Our ability, however, to promptly bring about this desired result will be lessened by any delay in its employment, on account of the resistance offered by excessive engorgement of the tissues and formation of adhesions between the iris and the lens capsule. An attempt made to dilate the pupil late in the progress of the disease may be met by great difficulty or even absolute failure owing to the density of the adhesions formed. The paramount importance of atropine in combating the formation of iritic adhesions, can only be appreciated by those who have witnessed the destructive changes which almost surely take place from the obliteration of the circulation between the aqueous chambers in those cases where the iris has been allowed to attach itself permanently and extensively to the surface of the lens; producing the conditions known as exclusion and occlusion, of the pupil.

The establishment of a full pupillary dilatation is then, first and last, the greatest essential in the management of iritis generally; and as a rule the frequency of application and strength of preparation is only limited by the resistance offering to the accomplishment of this end. In early stages and mild attacks, one instillation of a 4-grain solution three or four times a day will suffice. When the tissues are greatly engorged, we can usually only overcome the opposition thus presented, by setting up a cumulative action through its use, say every ten minutes for an hour at a time, three times daily. It has been found that a 4 per cent. solution of cocaine used with the atropine in some cases increases materially the action of the latter. After full mydriasis has been established only sufficiently frequent instillations are required as will maintain the dilatation. The only important contra-indication to the use of atropine in iritis, is found

in the comparatively rare form of serous iritis, or irido-cyclitis, in which there is sometimes noticed a tendency to increased intra-ocular tension. As a rule, however, there is here less disposition shown to contraction of the pupil and formation of adhesions than in the plastic variety. The same tendency toward glaucomatous tension exists in those cases where annular synechia has been so completely established as to entirely cut off the circulation between the aqueous chambers; in such a state atropine can only do harm.

In *abrasions and wounds of the cornea and in all forms of keratitis*, particularly of the ulcerative type, atropine, while not always an essential, exercises a most beneficial influence both on account of its quieting action and because of the disposition which always exists to the development of iritis in conjunction with all lesions of the cornea.

The favorable action of atropine in keratitis, is best seen in the treatment of that very common disease in children, known as phlyctenular or lymphatic ophthalmia. Here we frequently find that the tormenting and stubborn photophobia and blepharospasm, which so commonly complicates the case and protracts the duration of the disease will promptly yield and improvement set in so soon as wide pupillary dilatation is secured. In these cases, owing to the violence of the iritic spasm and the dilution of the atropine by the free flow of tears, the plan of frequent instillation at the hands of the physician is usually advisable until full mydriasis is accomplished which can be then kept up by a drop of the liquid used three or four times daily at home.

In this connection I would emphasize the point that where frequently repeated instillations are deemed necessary, and especially in the case of children who are more particularly susceptible to its action than adults, at least the first few applications of the atropine should if possible be made by the physician himself, and the effect carefully watched in order that distressing or serious symptoms arising from general intoxication may be promptly combated. In certain very rare cases of idiosyncrasy the use of atropine becomes quite impossible, but may usually be replaced by one of the other mydriatics.

For diagnostic purposes a dilatation of the pupil is not infrequently required to bring more fully to view the structures lying posterior to the iris; but while atropine accomplishes this object very perfectly its use is open to two serious objections; first, if unwittingly applied in a case of non-inflammatory glaucoma, a disease which

often presents no outward sign of its existence, the drug may precipitate, or convert this condition into an acute inflammatory attack with all its disastrous consequences; again, through the accompanying paralysis of the accommodation the patient may be put to much inconvenience through the loss of his power to clearly distinguish near objects during a period of a week or more following the examination. As we possess in cocaine a safer mydriatic and yet one sufficiently effective for simple pupillary dilatation, the indiscriminate use of atropine simply as a pupil dilator in diagnosis cannot be too strongly condemned.

Of the employment of atropine in the *estimation of refractive errors*, I shall say nothing, as this belongs more particularly to the sphere of the specialist.

As to the *contra-indications* for the use of atropine, although as I have intimated certain risks are run by reckless use in the case of children, and with those where there exists a peculiar susceptibility to its action, still, these dangers are trifling compared with the greater one arising from its employment in cases where glaucoma is present or imminent. That the use of this or even less powerful mydriatics has frequently been the means of greatly aggravating, or even developing glaucoma in an eye so predisposed, is a matter beyond all question, and as in the inflammatory variety there is unfortunately a more or less well-marked symptomatic resemblance to so common a disease as iritis, an affection, the treatment of which demands the free use of the very agent most to be avoided in glaucoma, I take the liberty of recalling to your mind the more prominent symptoms of these two disorders—their more important points of resemblance and dissimilarity. As has elsewhere been remarked the general practitioner who treats eye-diseases unless exceptionally well-informed is beset by dangers—a Scylla and Charybdis, in fact; on the one hand, blindness from adhesions if atropine is neglected, in iritis; on the other, a fatal glaucoma if it should be employed in unsuitable cases.

In both iritis and inflammatory glaucoma, the conjunctiva of the ball will be found reddened, especially immediately around the corneal margin; in both, there will appear more or less marked, a steaminess of cornea and iris; dimness of vision, pain in and about the eye and head, photophobia and lachrymation are fairly constant symptoms and common to both diseases.

But in glaucoma, the surface of the cornea will be found more or less anæsthetic, while in iritis it will be abnormally sensitive. In

glaucoma the pupil will be found moderately or widely dilated, while in iritis the pupil is almost invariably contracted. In glaucoma the anterior chamber will be found shallow, while in iritis the depth of the chamber is unchanged.

Though the state of the intra-ocular tension the shape and size of the field of vision, and appearance of optic disc, are to the specialist points of great importance, I shall lay but little stress upon them in connection with our present subject ; first, because few general practitioners would be capable of determining them with certainty, and secondly, because the other symptomatic variations already given, if carefully sought for, should be sufficient guide so far as the question with regard to the use of atropine is concerned.

The risk of converting an unnoticed and non-inflammatory glaucoma into an acute attack through the use of atropine is one that could only be avoided by previous examination of the face of the optic nerve for signs of optic nerve excavation and by a careful testing both of the ocular tension and field of vision ; but, as before intimated, it could hardly be expected that the general practitioner would be prepared to say with any certainty that an eyeball is below or above its standard of hardness, and he could hardly be expected to provide himself with the means for field-taking, etc. ; hence the only remedy will lie in a most cautious use or avoidance of mydriatics and more especially that most powerful one, atropine, in all cases past middle life—the period before which glaucoma is most rare—where there may exist with an unaccountable impairment of vision a sluggish, dilated pupil and perhaps a suspicion of corneal anæsthesia.

To recapitulate symptomatically by way of formulating rules for guidance I should say :—

1. Atropine may be employed to *advantage* or its use be *absolutely demanded* in all inflammatory and traumatic conditions associated with photophobia, lachrymation and pain, more or less impairment of vision, circumcorneal redness, dimness of cornea, or iris, or both, *plus a contracted pupil* (spasmodic or otherwise), and this picture would cover fairly well iritic and corneal inflammations.

2. The *avoidance* of atropine is *imperative* in all cases associated with photophobia, lachrymation and pain, more or less impaired vision, a circumcorneal redness, a steamy, insensitive cornea, plus a dull, *dilated iris*—and this picture would correspond sufficiently well to the ordinary inflammatory glaucoma.

In fact, for all practical purposes, so far as the general practitioner

is concerned, the distinction might, in a general way, be safely narrowed down to this :

A contracted pupil calls for or justifies the use of atropine.

A dilated pupil is a distinct warning against the use of atropine ; since glaucoma is the only inflammatory affection, excepting serous iritis, in which the pupil is found enlarged.

ATLANTIC CITY IN AUTUMN.

BY M. D. YOUNGMAN, M.D., ATLANTIC CITY, N. J.

THERE has existed a popular belief that all places ranking as "summer resorts" are, after the close of the "season," in an unhealthful or unsanitary condition. And this belief has existed particularly with regard to those summer resorts along the seacoast, and especially to the more populous ones. Indeed, one often meets persons who think that as the "season" is drawing to a close they must arrange for their departure; and then one hears of people who desired to go to the seashore after the close of the "season," but were deterred by the fear or superstition that it was unsafe to do so, all because of the supposed unhealthfulness of the place in consequence of the large crowds who have been accommodated during the heated term.

This belief (let its foundation in truth be what it may) has, without doubt, been a considerable factor in preventing people visiting the seashore during the fall months; and while it may have some basis of truth in those places of resort not provided with an adequate system of drainage for surface water, or sewerage for houses, and where the ground privy is used, surface water is drunk, etc., it is emphatically not true of Atlantic City.

In Atlantic City—the most popular and populous resort along the Atlantic seaboard—the cleanliness and healthfulness of the city is as great during the month of September as during June, for the same effective means of maintaining a constant state of sanitation exists as well during the *progress* of the season, and at its close, and every day of the year, as at the inception of the grand rush in June.

And it is not matter of surprise that this should be so, for Atlantic City is accustomed to, and equipped for, caring for large crowds of visitors.

We have a sewerage system beyond comparison with any other resort in the United States ; our streets handsomely graded, carefully scraped, and provided with an admirable system of surface drainage. There is careful daily removal of garbage, an abundance of pure water, and there is no vegetation to rot in the autumn and produce the vegetable fungi germs and spores so dangerous to health, and which give rise to many of the fevers prevalent in the fall of the year throughout the country generally.

That people go home sick from here, or are taken ill after reaching home, is conceded. Nor is this to be wondered at when one considers the life these people live while here. All regard of proper precautions and care is set at naught ; the laws of nature and health are violated with a recklessness they would not dream of at home ; over-eating, over-excitement, over-fatigue, dancing, gaiety, dissipation, all contribute to undermine the vitality ; outraged nature demands her penalty, an autogenetic fever is the result, and the blame is heaped upon the place.

The writer has been Secretary of the Board of Health of Atlantic City for five years, and can testify to the entire absence of malarial, typhoid or other zymotic disease during the fall of the year. Cases do occur during the summer when we have people coming to us from all over the country whose systems are impregnated with the seeds of these diseases, but care and quarantine control these sporadic cases. Statistics in the records of the board show less sickness and a lower death-rate during the months of September and October than any other months of the year.

The Board of Health is an efficient and active body, ably supported by the city government and the popular voice. This board has an inspector, employed by the year, whose duty it is to exercise a vigilance over the health conditions of the city. Part of this duty consists of a "house-to-house" inspection, one made in April and another in September. During the summer months an additional or "assistant" inspector is employed. And thus the sanitary conditions of this model summer resort are carefully watched.

The months of September and October are extremely pleasant and enjoyable here, and year after year an increasing number of visitors are appreciating this fact. The great surging, ever-changing crowds are gone ; the sea of human faces on the beach and boardwalk has ebbed ; the "Babel of voices" has ceased and quiet and peace reigns ; the bathing is delightful ; the air deliciously cool and bracing ; the fishing, crabbing and boating are at their best ; there is freedom from

decomposing vegetation, so objectionable in mountain resorts and those on the mainland.

There are comfortable hotels, quiet and ease in the atmosphere (literally and metaphorically), and great ease of access,—all prime recommendations for these two charming months at the sea-shore, and especially to those who wish to “top off” a summer spent in the mountains with a couple of weeks at the “shore.”

Sufferers from autumnal catarrh, which is essentially a variety of hay fever, enjoy great relief from their malady here, as well as the delights of glorious old ocean.

Delicate people, and those susceptible to the malarial and typhoid influences of the autumn in towns and cities, would do well to spend their fall months in Atlantic City, where immunity from danger is assured.

ON THE IMPOSSIBILITY OF DIAGNOSING PHTHISIS PULMONALIS IN THE EARLIER STAGES WITH CERTAINTY WITHOUT THE EVIDENCE AFFORDED BY PHYSICAL SIGNS.

BY EDWARD R. SNADER, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society of the County of Philadelphia, November 10, 1892.)

A LACK of a proper conception of the value of careful and systematic explorations of the thoracic organs by the methods of physical diagnosis in cases in which the existence of lung disease can be rationally suspected, leads many physicians, in making a diagnosis, to wholly ignore the importance of physical signs indicating actual structural changes in the pulmonary parenchyma. This undervaluation of physical signs has its origin in several causes, perhaps the chief of which is the inability to detect the slight modifications that occur in the percussion note, in the respiratory murmur, in the loud and whispered voice, and in the changes in the fremitus, appreciable by auscultation when the lung structures are the seat of small solidifications.

Another cause contributing to the undervaluation of physical signs is a lack of knowledge of the resources at the command of the practiced physical examiner; in other words, of the various modifications that can with advantage be made in the usual methods of interrogating the structures within the thorax. The loud and whis-

pered voice, and the voice vibrations (or fremitus) may all be made subservient to confirm findings by grosser methods, and, under certain circumstances, when the more generally employed methods fail apparently to elicit sufficient evidence of structural deviations, the loud and whispered voice and the fremitus furnish evidence just as indubitable as to the existence or non-existence of lung lesions as changes in the percussion note and modifications in the respiratory sounds. Indeed, in some cases, owing to various obvious causes, changes in the loud and whispered voice and in the fremitus (particularly the fremitus appreciated by auscultation, not by palpation), furnish the necessary evidence of normality or abnormality of the lung tissues when the grosser methods fail to present the modifications usually found by percussion and auscultation.

The fact that physical exploration may, in certain cases, prove difficult, and the application of the methods of physical diagnosis furnish negative results in the hands of some physicians, does not lessen in the least the positive necessity for the employment of these means of investigation; nor does it lead to an undervaluation of the positive results obtained by skilful examination.

The system of physical exploration must not be condemned because the individual is not competent to successfully employ its methods of investigation. The man, not the method, should be blamed. Nor, on the other hand, does the difficulty of obtaining exact diagnostic data by means of physical exploration lessen one iota the absolute necessity for that physical evidence of lung mischief, when a positive, rational diagnosis is to be reached. If the physical signs of structural alterations are absent, a link in the chain of evidence is wanting. Doubt reigns, not certainty. Because tissue changes cannot be found by physical examination easily and expeditiously, the belief is soon entertained by the average practitioner that these changes *cannot* be detected, and hence the opinion is reached that the diagnosis of diseases of the chest, and particularly of that common one, phthisis pulmonalis, must rest upon the presence of certain symptoms.

I submit that the view that a positive diagnosis of phthisis pulmonalis in its earlier stages can be made by symptoms alone is grossly erroneous.

The rational, tenable, common-sense diagnosis rests upon the presence of certain physical signs *and* the symptoms. The signs are more valuable than the symptoms. The signs and symptoms should seldom be divorced. The diagnosis does not often rest upon the

physical signs alone. The diagnosis never rests upon the symptoms alone.

Let us glance for a moment at the symptoms that are usually depended upon in making a diagnosis of pulmonary consumption upon a symptomatic basis. Cough, expectoration, blood-spitting, loss of flesh, night-sweats.

This is, indeed, a very suggestive combination of symptoms ; but the whole group is not positive evidence of the existence of a lung lesion. If you add to this group, as some do, a peculiar temperature and a rapid pulse, you are no nearer a positive and indubitable diagnosis than before. If you add, too, loss of weight, loss of appetite, and the so-called phthisical dyspepsia, and the phthisical desire for meats, and debility, you are no closer to a scientific solution of the diagnostic problem than at first. Why? Because all these symptoms can be present in one group, or in various combinations, and yet, the patient not have consumption. Any *one* of the first-named symptoms, or a limited grouping, taken in connection with the physical signs, is sufficient for a positive diagnosis.

To consider the first group of symptoms as indicating phthisis, would be on a par with believing every sharp pain in the chest either a pneumonia or pleurisy ; every sharp pain in the abdomen, with a rise of temperature, as peritonitis ; every case of dysuria as cystitis ; every red face, with fever, as scarlatina ; every absent patellar reflex as an evidence of locomotor ataxia ; every murmur heard while listening to the heart as proof positive of an organic valvular lesion ; every case of albuminuria as Bright's disease ; every pain in the back of a female as a sure sign of uterine displacement ; every tumor that caused pain as malignant ; and every croupy cough as diphtheritic laryngitis.

No one, who has a proper conception of diagnosis, can believe that diagnoses made in such slipshod style are scientific. They are correct only by accident. We want accuracy, not guessing.

Concerning so common a disease as consumption of the lungs, we should be able to speak positively.

Cough, we all know, is a symptom present in all forms of pulmonary and pleural disease, and, indeed, is of nasal, pharyngeal, laryngeal, aural, and cardiac, and even visceral origin.

Expectoration can occur from any lesion affecting the mucous membrane along the respiratory tract, from the nares down to the finest bronchial ramifications and air-cells, but the practical physician knows that certain forms or kinds of sputa are by no means abso-

lutely diagnostic of the particular lesions peculiar sputas are presumed to represent.

Bloodspitting, aside from its occurrence in other forms of lung disease than phthisis pulmonalis, and from cardiac disorders, hæmaphilla, scurvy, and vicariously, can occur also, as does expectoration, from a lesion anywhere along the respiratory tract. The significance of bloodspitting is very great, indeed, if it be coupled with the physical signs of lung solidification. Without the presence of signs indicating pulmonary involvement, its cause must be found elsewhere, and hæmoptysis must not be blindly referred to the lungs as its only possible origin. I have knowledge of at least five patients who were treated for pulmonary phthisis because they spit blood, and presented one or two other so-called characteristic symptoms; in all these cases the lungs were free from discoverable disease, and the blood came from the buccal cavity, *i.e.*, from the gums and decaying teeth. The other symptoms presented in the patients belonged in the symptomatic phenomena accompanying other diseases as well as phthisis pulmonalis, and their presence was readily accounted for. One case of pharyngeal hæmorrhage, from a ruptured vessel in the pharyngeal wall, was ordered to Southern California on account of supposed lung disease. I know of one case, a lady, who had frequent severe hæmorrhages, that appeared uncontrollable at times. She wasted, had fever, cough, and rapid pulse; she recovered rapidly from her phthisis pulmonalis when her dentist found a ruptured artery in a hollow tooth.

Sweats occur in other forms of thoracic disease than phthisis, with certain nervous disorders, in anæmia, in the sedentary, in simple debility, and in other maladies. Rapid disintegration of lung tissue often takes place without this symptom being present, and, indeed, in the very last stage of the disease are seldom complained of.

The temperature curve is not an absolute guide. We all know how frequently the typical temperatures of the books, in various diseases, is not found. We are simply beginning to learn something of the value of the clinical thermometer in medicine. We cannot assert that we have learned all we can, nor that the clinical deductions to be drawn from certain peculiarities of temperature curve are unmistakable as to the presence of certain diseases. I do not think observations have been sufficiently extensive regarding thermometry in phthisis for one to be dogmatic enough to assert that any temperature curve, however peculiar and marked, is absolutely diagnostic of phthisis pulmonalis and of no other disease. Certain it is that I

have seen all sorts of temperature curves in active phthisis pulmonalis, and have seen cases rapidly going the down grade to the grave with a normal or sub-normal temperature. If I cannot rely upon the presence of the peculiar temperature to give significance to a group of symptoms, because it is so frequently absent, I certainly cannot rely upon it to diagnose a certain form of disease and no other. In other words, a certain temperature curve is of value, but is not absolutely diagnostic; it has a suggestive value, and in its correlation to other signs and symptoms, may furnish concomitant evidence lending greater strength to the available diagnostic criteria, but of itself is not diagnostic. I recall very distinctly the case of a young man who had the usual symptoms of phthisis, and his physician discovered that he had a morning temperature of $97\frac{2}{5}^{\circ}$ F., and an afternoon temperature of $99\frac{4}{5}^{\circ}$ F. The thermometer, in this particular case, was made the instrument of precision by which a diagnosis of phthisis pulmonalis was reached. I could not discover in his chest the shadow of anything that appeared abnormal. I had him take his temperature every day, morning and afternoon, for three weeks in the mouth and rectum simultaneously. I found the temperature 1° higher in the rectum than in the mouth, but presenting the same range exactly as that noted in the mouth. For three whole weeks the temperature curve in both rectum and mouth showed the daily variation of over 2° , with but a slight deviation of $\frac{2}{5}$ higher after an unusually hearty and late meal. It seemed to me that the belief was perfectly tenable that this temperature was normal to the patient. It certainly appeared to me that a temperature indicative of a febrile process in the lungs should show more oscillations than were registered by the regular rise and fall of this man's temperature. I have found in quite a number of persons, presumably healthy, and in others who suffered from malnutrition from various causes, marked deviations from a supposedly normal temperature. I do not regard such a variation *as of necessity* evidence of a named disease process anywhere. I have no doubt whatever that the discovery of variations such as I have shown occurred in the case just cited has led many a painstaking physician to erroneous diagnostic conclusions. Despite the fact that physiological investigations into normal temperature have been rather limited, and that many authors permit of as great a range as 2° F. in the diurnal and nocturnal course of normal temperature, some physicians insist on regarding a temperature at all above $98\frac{2}{5}^{\circ}$ F. as an evidence of fever, no matter what time of the day the record is taken.

When the whole group of symptoms are present that are regarded as diagnostic of consumption of the lungs, and yet, in some cases, at least, a proper analysis of the symptoms and an absence of physical signs of lung consolidation, leads to a reversal of the diagnosis of phthisis pulmonalis, how much more difficult is it to diagnose the disease when only one or two of the symptoms are present, if the diagnosis is to rest upon a symptomatic basis only? Besides, when the whole group of symptoms are present at one time the disease is generally far advanced, and there is no difficulty for a tyro even to discover the physical evidences of lung mischief. Rationally, one symptom, no matter how apparently trivial, leads, with the discovery of the physical signs, to an early diagnosis long prior to the appearance of that dread tripod—emaciation, night-sweats, blood-spitting.

We have all seen cases of consumption who have not had a particle of blood-spitting from the onset to the termination of the disease, and yet hæmoptysis is the most suggestive and significant symptom of the whole group of phenomena that is looked upon as settling the diagnosis beyond peradventure. How often are night-sweats absent? How often is expectoration not found? Cases, too, are on record in which cough was not noted. I have personal knowledge of two cases of active, progressive phthisis in which cough was never a symptom, except when an acute bronchitis occasionally supervened during the downward progress of the malady. We know that loss of flesh is not at all a necessary symptom in early, or even in quite advanced, cases of phthisis, and this is particularly true when the disorder is confined to the lungs alone. How many, too, are the utterly dissimilar diseases of which loss of weight is a prominent symptom?

The symptoms alone, no matter how coherently grouped, are, in my opinion, only sufficient for an "inspired" guess—inspired, if the diagnosis accidentally turns out to have been correct; uninspired, if the case turns out to be one of those "unusual cases" we hear so much about, one of those mysteries of medicine that do not follow the beaten track of what might be called symptomatic clinical medicine.

You may ask: Do microscopic examinations of sputa help? I answer, Yes and No. If you ask, Will not the discovery of the tubercle bacilli in a specimen of sputa settle absolutely the nature of the malady? To this interrogation I answer most emphatically, No. Why does not the finding of this dread micro-organism settle the question? For several very good and substantial reasons. The

bacilli of Koch are presumably the cause of consumption, but they are unquestionably, not presumably, a product of the disease. The product of a disease can be found in situations other than where it originated. The mere fact of the discovery of a bacillum does not constitute absolute evidence that it had its origin where it was found. I mean that bacilli are distributed with more or less universality, as are other micro-organisms. It is a reasonable presumption that tubercle bacilli will frequently be found away from their birth-place. We all probably inhale tubercle bacilli often, and these germs remain for a longer or shorter period of time somewhere along the respiratory tract. If an examination of the sputum be made during the accidental presence of the bacilli, is that mere presence to be taken as a positive proof of the tuberculous nature of a given malady? I think not. How can it be determined whether the presence be accidental? That cannot be done unless the bacilli have set up secondary tissue changes, unless its presence has modified the pulmonary structures, and such modifications can best be discovered by means of physical diagnosis. It must not be forgotten that something beside the tubercle bacilli is necessary to establish pulmonary consumption, if the germ be the cause, and that something else is a peculiar soil. The seed and the soil are the essentials, not the seed alone, not the soil alone. Not every migratory germ produces disease, else all would quickly succumb to some one or other affection capable of being brought into being by bacilli. The mere fact of finding a germ, then, in a slide specimen of sputum does not constitute the certainty of a conclusion, either that it is an evidence of existing disease, or even that it will of necessity inaugurate a tuberculous malady.

If the soil be not present it will not cause disease; it is simply a "tramp" bug. The bacilli of Koch are not always present when the disease is tuberculous in its nature. Fairly abundant evidence is extant showing that, in cases pursuing the ordinary clinical course of consumption of the lungs, the germs are not discoverable in the sputa, even when persistent and long-continued search is made by skilled microscopists, the post-mortem showing the affections to have been unquestionably tubercular. Now, if we instal the tubercle bacilli as the sole and indisputable arbiter in the diagnosis of pulmonary tuberculosis, what is to become of those cases (in a diagnostic sense) in which this evidence afforded by the microscope is absent. If the bacilli be the judge that finally decides upon the matter, we must logically conclude that absence of germ means absence of tuberculous disease.

I do not desire, in the least, to decry the results of the investigations of the microscopists. I believe that the frequent discovery of bacilli in the sputum, particularly if they be abundant, is entitled to great weight. The germ's presence is strong evidence, but this evidence is liable to too frequent fluctuations to be considered as absolute, and particularly so when better methods are at hand to prove that a process is in progress in the pulmonary parenchyma, pursuing practically the same clinical course as the disease we commonly call consumption.

I object, only, to making the tubercle bacilli an absolute arbiter of the fact of the existence of a certain malady, of the exact nature of that malady, and of its situation.

The presence of the bacillus should be regarded as one of the physical signs, sometimes available for diagnostic purposes, sometimes not. When found frequently, it is correlative, circumstantial evidence of the nature of physical signs indicating consolidated lung structure. Its presence is suggestive, not conclusive. Muscular striæ are of far more value than the bacilli. I have knowledge of at least two cases, where, without a physical exploration of the chest, an examination of the sputum was made, the bacilli of Koch discovered, and a diagnosis of phthisis pulmonalis made. Both cases had post-nasal catarrh, not consumption, as the results of treatment showed. The lungs were absolutely normal, although the symptoms complained of were exceedingly suspicious.

Taking all things into consideration, I contend that the symptoms alone are not sufficient for early diagnosis; that the presence of the tubercle bacilli is, generally, only suggestive, and that the diagnosis must rest upon the finding of the physical signs indicating structural lung change and the symptoms.

Are the physical signs always available? If I take my personal experience of late years, Yes. I have heard of two cases in which it was declared that no signs were discovered, in the early stage, when the symptoms complained of seemed to indicate consumption. I do not know whether the examinations of the chest were frequent or not. Such cases must, indeed, be exceedingly rare, and must show a unique central distribution of consolidated foci, and do not, in the least, invalidate the proposition that the physical signs are necessary for a rational diagnosis. Such cases must be rare, and can only remain rare for an exceedingly short period of time. I cannot conceive of the development of active symptoms prior to the development of the cause of the symptoms. With the symptoms of the mo-

ment of inception we are none of us acquainted, and therefore the first indications would be overlooked altogether, or ascribed to other diseases. A lung lesion, if it be active, must evolve the symptoms of that lesion. Alterations in the lesion, and in associated conditions, give rise to alterations in the symptoms, other things being equal, and symptoms and lesions march along side by side.

My personal experience leads me to the inference that, in many cases at least, the physical signs indicating lesions are present for a considerable time before the appearance of symptoms, and, therefore, should be discoverable long before the symptoms begin to line themselves up in definite and suggestive array. I will cite an instance which will illustrate this point. I wanted material to demonstrate the disparities of the normal chest to a class of students, and selected a strongly-built, perfectly healthy-looking young man for the purpose. He had taken cold three days before, and had a slight cough due to an acute pharyngitis. He had no fever, and no other symptoms. On inspection he displayed a magnificently-proportioned chest. To my own supreme surprise, I found spots of consolidation as large as a small coin, here and there over both summits, but particularly at the left. The class actually smiled when I made a diagnosis of incipient phthisis pulmonalis. Two months later I treated that same man for a violent pulmonary hæmorrhage. His case pursued an unusually rapid downward course.

Another case where I was able to make out pulmonary consolidation prior to the appearance of symptoms indicating lung involvement was in a patient who consulted me over three years ago on account of a valvular heart disease. In the course of a systematic general examination I discovered a small solidification at the summit on the left side. I treated the man for six months without the appearance of symptoms referable to the lungs. I then lost sight of the case until two months ago when I was summoned to stop a hæmoptysis. The spot in the left lung now shows signs of tissue breakdown; lesions are now discoverable elsewhere also. Aside from occasional palpitation, he considered himself a well man until about a week prior to the occurrence of the hæmoptysis.

I have seen a number of similar cases in which lung solidification was easily discoverable before the appearance of symptoms of activity, and I have also seen a number of cases in which the signs and symptoms have shown activity, and the symptoms have disappeared, the physical signs remaining as monuments of a former malady.

It seems to me that a careful consideration of all the greater fac-

tors involved in a discussion of a question of this nature, must lead inevitably to the conclusion that it is impossible to make a rational, tenable, positive, scientific diagnosis of phthisis pulmonalis, in its earlier stages at least, if not in all, without the aid of physical signs. The signs and symptoms are the alpha and omega of the diagnosis.

I believe that the lay public has a just right to demand of us a positive diagnosis at a period of the disease when we will have an opportunity to combat the enemy. In a disease that has been prevalent since the dawn of time, that is pandemic, epidemic and endemic, that has slaughtered more lives than all engines of war, that enters nearly every household, that is no respecter of persons, that fronts us every day, that threatens us and those who belong to us every hour, I repeat, the public has a right to demand of the medical profession a rational diagnosis, no matter how difficult the acquisition of the knowledge requisite to make that diagnosis may prove.

We dare not wait until a neighborly old lady tells the family "that boy has consumption," until we hear that hollow cough, see that feeble gait, the bowed frame, the wasted, bony form, the bright glitter of the hopeful eyes, the wan cheek, on whose malar mountains Hectic rears her red flaunting flag of victory, symbolizing the triumphant tramp of the myriad armies of germs in the lungs below who have swept over the connective-tissue forts and laid waste the airless plains of tissue, and have mined and riddled the lungs into great caverns, and one of the citadels of life is despairingly surrendering.

If the medical profession fails to avail itself of the positive evidence furnished by means of physical diagnosis they are turning their backs upon progress, they are returning to the dark ages of medicine before the labors of Laennec, Piorry and Avenbrugger shed so much light upon darkness, to a day when acute bronchitis, chronic bronchitis, pleurisy, phthisis, catarrhal pneumonia, croupous pneumonia, and intercostal neuralgia, were continually mistaken the one for the other. How could it be otherwise without the precisionizing data given us by percussion and auscultation?

How awry must prognosis have been in those old days! What champion sophists, to put it mildly, medical men had to be in those days when they could not tell positively what was the matter, and they continually found cases doing what could not be expected of them, dying when they should have gotten well, and living when they should have died.

Let us not go backward.

ADDRESS BEFORE THE HOMŒOPATHIC MEDICAL SOCIETY OF THE
COUNTY OF KINGS.

BY WILLIAM MORRIS BUTLER, M.D., BROOKLYN, N. Y.

LADIES AND GENTLEMEN :

In laying down the office with which you intrusted me at your last election, I desire to thank you for the cordial support which you have given me, as your President, during the past year.

The meetings have been well attended, and the chairmen of the various bureaus, faithful to their promises, have, in each instance, furnished us with interesting and instructive papers. It might be suggested that the profitableness of our future gatherings would be largely increased by more thoughtful discussion of the papers presented. Let certain members, previously chosen, come prepared upon the subjects of the evening, in order that their comments and remarks may be the result of mature deliberation and worthy of consideration. This has already been advised by the Executive Committee, but has thus far not been carried into action. We would also recommend the continuance of the Committees on Drug Proving and Verifications, General Health, and also the one to act as our representative upon the Advisory Board of the City Health Commissioner.

The meetings of the past year cannot have failed of being profitable to those who have been present, and I bespeak for my successor the same encouraging co-operation upon your part, in the coming year, that you have tendered me in the one just passed. Persistent, continued, united co-operation upon the part of all the physicians of our school can alone produce the effect which homœopathy should exert upon the community at large.

The past year may be regarded as one of the most important since the establishment of our school. During this year the State Board of Medical Examiners has been organized, and, through its Syllabus Committee, has decided upon a broad and liberal policy, which must be adopted by the medical instructors of the homœopathic school in this State. The great importance of this step is apparent when we reflect that from Hahnemann's time to the present no authoritative standard of medical education has existed in our school. In establishing the State Board of Medical Examiners, it became incumbent upon the homœopathic representatives on the board, in framing their

syllabus of examination, to determine upon and incorporate in that work a standard of requirement in these branches, which should be at once a truthful reflex of the homœopathy of this day, and an index for the guidance of our medical colleges in the future instruction of their students. For it follows, as a matter of course, that the colleges must and will prepare their students for what they themselves desire and demand, namely, the license of the State. As the law reads, "that in the department of therapeutics, practice and materia medica the questions shall be in harmony with the tenets of the school selected by the candidate," it became necessary for the members to determine what were the tenets of the homœopathic school. Upon this point a great diversity of opinion appeared among the different members. The points at issue were whether, under materia medica and therapeutics, should be introduced questions upon toxicology—including poisons and antidotes—and the physiological effects, uses and doses of drugs. It seems hardly credible that a body of educated physicians, representing and prescribing for the most intelligent class of the community, could seriously have considered the allowing of a body of physicians to go out into practice without knowing whether they knew how to antidote a poison or were able to tell whether a patient had taken a poisonous dose of morphine or not. Yet such was the case, and only after a most persistent fight upon the part of our Brooklyn representative, and an appeal to the attorney-general, was the present broad and liberal standard adopted. This course was consistent with the entire history of our school. The law demanding preliminary education from the medical student was born in our school. The law organizing State boards of examination became such mainly and originally by our efforts. Always and everywhere homœopathy has been synonymous with sound learning and the most vigorous proofs of the same, and any other course would have been one of retrogression, and, as the Dean of the New York Homœopathic College emphatically asserted, would have put our school back fifty years. Our school, being supported by the best educated and most intelligent class of the community, cannot stand still—it must move forward.

The present is a time of crucial interest to our school, not only in our State, but throughout the United States. When we consider that the Committee on Programme and Order of Business of the American Institute of Homœopathy, at their meeting in Waukesha, Wisconsin, seriously recommended that the Bureau of Anatomy,

Physiology and Pathology be dropped from the work of the Institute and the papers assigned to other bureaus, it seems imperative that the physicians of our school should be continually upon their guard. Homœopaths cannot know too much. Nothing is too good for homœopathy. Do you not believe that we can be as much benefited by pathological and histological research as the members of the old school? Are we to be content with a knowledge of *materia medica* and the principles of the *Organon* alone? Our school cannot stand still and live. We cannot know too much *materia medica* or be too loyal to our foundation law of similars, but thoroughness in this department should not debar us from the most thorough knowledge of all other departments of medical science which can aid us in our battle against disease. Possessed of a positive law of cure which allopathy lacks, if to this is added a thorough knowledge of anatomy, physiology, pathology, histology, and all the advancements of modern science, homœopathy cannot fail of placing itself, in the future, far in the van of medical science.

Nor should our school content itself with simply ministering to the sick. Much could and should be done in the line of public instruction regarding hygiene and the general laws of health. When we consider the dense ignorance prevalent among the lower classes, it is no wonder that the children of the tenement classes die in herds and that here is ever found ample material to feed and fan into a flame the sparks of any epidemic which may spring up in any of our large cities. The matron of one of our seaside sanitariums states that not less than eighty-five per cent. of the mothers who came there in the summer acknowledged that they never gave their children baths; that it was a common thing to have a mother ask, when told by the resident physician to give her child a warm bath, "How shall I do it, sir?" Nor do they know more regarding the preparation of food for their families. Of 244 women, all wives and mothers, questioned by Lilian N. Betts, it was found that only five knew how to make bread, and one did make it; two made soup once in a while; a few cooked fish. That nothing was known of cooking beyond frying meat and boiling a few vegetables. Is it any wonder that poverty increases under such conditions, that the husbands throng the liquor shops and the children sink into early graves? Nor is ignorance regarding hygiene and the ordinary laws of health confined to the lower classes; the graduates of our high schools and universities know little more. Mr. Herbert Spencer, in a scathing criticism on the incompleteness and folly of our present system of education, says:

“Men who would blush if caught saying Iph-i-gé-nia instead of Iph-i-ge-ni-a, or would resent as insult any imputation of ignorance respecting the fabled labors of a fabled demi-god, show not the slightest shame in confessing that they do not know where the Eustachian tubes are, what are the actions of the spinal cord, what is the normal rate of pulsation, or how the lungs are inflated. While anxious that their sons should be well up in the superstitions of two thousand years ago, they care not that they should be taught anything about the structure and functions of their own bodies—nay, would even disapprove such instruction.” Is it any wonder that epidemics of typhoid fever have produced the greatest consternation in Princeton and Yale, when it is known that the professors in charge of these institutions are not only careless regarding the ordinary rules of hygiene, but even ignorant of these laws? Surely, we can never expect to be freed from frequent epidemic visitations as long as the most intelligent classes of the community are content to remain in ignorance of the means necessary to the prevention of their occurrence. This has become a matter of vital importance to the national health. How is this crusade against medical ignorance to be successfully carried on? By the medical profession, through the public school system instructing the lower classes, and through the higher schools and universities enlightening the educated classes. In this manner a more successful quarantine against disease and death will be established than can ever be founded by State or national legislation. Let us, as a society, through our Committee on General Health, commence this crusade. Let the members, by direct communication with the Board of Education, strenuously insist upon the necessity of the introduction of instruction upon these matters in our public schools, and it will not be long before the fruits of our labors will be shown in a general betterment of the community. This will be no easy task, and can only be accomplished by continued persistent effort, but the end will amply repay for the labor expended. The Homœopathic Society of the County of Kings has enough men and women of brains within its fold to make itself felt as a power in the community if it will only bestir itself and let itself be heard.

ARGENTUM NITRICUM IN THROAT AFFECTIONS OF SMOKERS.—T. F. Allen says argentum nitricum is a valuable remedy in catarrhal affections of the throat in smokers. The fauces are generally dark-red, there is much tenacious mucus, and sensation as if a splinter was lodged in the throat.—*Chironian*, January 25, 1893.

THE AETIOLOGY OF ALBUMINURIA OF PREGNANCY.

BY THEODORE J. GRAMM, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

It will probably be generally admitted that the ætiology of albuminuria of pregnancy, and a correct appreciation of the clinical significance of albumin in the urine of a pregnant woman, present problems not readily solved. The elements of difficulty lie in the facts that we have to deal with unstable organic compounds, whose composition is in some instances not as yet fully determined, and whose recognition is at all times associated with great liability to error. In addition to this we have to deal with organs of complex anatomical formation whose functions, while in the main recognized to be excretory, are not sufficiently well understood, and the same may be said of the disturbances from which the kidneys suffer, especially from causes which are remote.

The mode of production of the clinical symptom "albuminuria" is one also which is not wholly settled, but is known to be influenced by many and diverse causes and conditions. When, therefore, we add the influence of pregnancy, affecting the economy as it does in many ways, we cannot avoid the conviction that in studying the ætiology of albuminuria occurring during pregnancy, a task is undertaken which is not altogether easy of accomplishment.

Albumin is not a normal constituent of the urine in health, hence its presence is indicative of a pathological condition. Neither is the pregnant state normally associated with albuminous urine. When, therefore, albumin is demonstrated to be present in the urine, it is now no longer a condition of doubtful significance; but, in view of the fact that albuminuria is often associated with serious and fatal disease, the attempt should be made at once to determine its cause. In pregnancy is this especially true, since the dangers ordinarily incident to albuminuria are as imminent as in other conditions, and, moreover, are augmented by other and more proximate dangers, such as eclampsia, loss of vision and paralysis. Of course, it is well known that albuminuria and nephritis are not synonymous terms, nor is the significance of albumin in the urine identical in different cases. In this is indicated an interesting field for study, but one which cannot be entered upon at present, since this paper is intended to be only suggestive and introductory to the discussion which it is hoped will follow.

In attempting to study the ætiology of albuminuria of pregnancy, there are some considerations which should be borne in mind, of which an important one is that while pregnancy is a physiological state, yet under no other circumstances are the various organs of the body called upon to functionate so closely near the border line between health and disease, and it is not to be wondered at if sometimes this line be overstepped and a diseased condition exist. That this should be so can readily be understood when we consider the changes normally produced by pregnancy. The most important of these are the hydræmic condition of the blood, due to the increased demands of the foetus and the increased tissue waste, at the same time that the capacity to take and assimilate food are frequently interfered with. There is likewise, in the later months, an increased amount of blood according to recent investigations, which, however, is deficient in red blood corpuscles and iron, while the white corpuscles are increased. The water is increased, and the blood contains a relatively greater amount of fibrinogen, resembling therefore the blood of inflammation. At all times there is an increased arterial tension. The amount of urine also is increased, requiring a larger amount of work by the eliminating structures of the kidneys.

Another important change brought about by the existence of pregnancy is in the nervous system. Lusk sums up the matter concisely in a single paragraph: "The nervous system becomes more impressionable. The whole character frequently undergoes a change. The most amiable of women are liable to become fretful, peevish and unreasonable. The spirits are often depressed, especially in the earlier months, when the general nutrition is most impaired. The melancholia in women already predisposed to insanity may terminate in mania. The memory is generally weakened, especially in women who have borne a number of children in rapid succession. On the other hand, nervous women sometimes lose their nervousness, and exceptionally there are individuals who experience during pregnancy a peculiar sense of well-being. Neuralgic affections are common (faceache, toothache, etc.); local anæsthesia and paresis occur at times; the senses are often disordered (nyctalopia, amaurosis, amblyopia, deafness, perversions of taste and smell); pruritus is sometimes troublesome; and, finally, pregnant women are subject to attacks of dizziness and syncope."

When we take these facts into consideration, showing that every part of the nervous system may become affected, especially in conjunction with the facts concerning the minute anatomy of nerve ter-

mination in the kidney structure, it becomes explicable how pregnancy certainly is in itself a predisposing cause of albuminuria.

From the foregoing it will also be seen that the changes inaugurated in the general organism are of such a character that their greatest influence would seem to be thrown upon the excretory organs, and on the kidneys in particular. From these considerations it would be natural to infer that pregnancy may induce certain changes in the kidneys, and such has been found to be the case by Leyden and Winckel. They describe the kidneys as being rather large, pale and anæmic. Microscopically, the epithelium is shown to have undergone fatty degeneration. Inflammatory changes are lacking, but such changes as exist appear to be due to the anæmia. While these changes may occur to a certain extent in all cases of pregnancy, their effect is not the same in each; otherwise albuminuria would be far more frequent. These, however, may be the origin of many cases of pronounced albuminuria, and in others they may constitute the condition present, which intensifies other remote influences to the extent of carrying the general condition from one regarded as within the bounds of health into one of disease; for true it is that that which under the stress of pregnancy must be regarded as physiological, without it would undoubtedly be looked upon as pathological.

It has been said above that albuminuria does not occur normally during pregnancy. Neither does it occur as an abnormal condition which attends every pregnancy, but its frequency is variously estimated at from one to twenty per centum, and often stated to be five per centum. It occurs most frequently during the later months, especially after the sixth month and during labor, though it has been found as early as the sixth week. It is more frequent in young women than those farther advanced in life, and is said to affect primipara often, though in multiple pregnancies albumin is often found in the urine.

When any number of cases are examined in which albumin occurs in the urine, it is found that all do not pursue the same course nor terminate in the same manner. There is, therefore, no essential albuminuria of pregnancy, but each case is to be regarded, not as one of a given disease whose course and termination are more or less determined, but we should rather look upon the patient as one having a clinical symptom whose import is by no means fixed, and one which, under other circumstances and in another patient, would have a different significance.

From this standpoint, and it is one likewise held by many recent authors, the entire subject assumes a different aspect. Holding this view, the subject is at once simplified as to its theoretic considerations, and in a given case much more complicated, since it no longer admits of a routine classification of an albuminuria as puerperal nephritis. The necessity arises for a far more accurate study and a much more extended examination in order to diagnose the case and classify it as belonging to a group originating in a similar manner. On the other hand, it would appear to be equally fallacious and misleading to cast aside the influences of pregnancy, potent as they are in their effects upon the blood and upon every division of the nervous system.

As is well known, the subject of albuminuria and diseases of the kidney are closely associated with the name of Richard Bright, who, in 1827, showed their relationship in his "Report of Medical Cases," and since then the various forms of nephritis and albuminuria have been associated in the medical mind, and these terms have been applied at times as if synonymous, though erroneously so.

In 1842 Lever pointed out the close connection between albuminuria and eclampsia, and the fact that in the majority of cases of puerperal convulsions albumin in large quantities was present in the urine, and said that the albuminuria caused the eclampsia, and that eclampsia never existed without albuminuria.

At that time the convulsions were thought to be uræmic. But it was found that urea injected into the veins did not cause convulsions. Frerichs then suggested that the urea decomposed into carbonate of ammonia in the blood. This decomposition was disputed, since the injection of ammonium carbonate was not followed by convulsions. It was therefore thought that other of the urinary constituents remained in the blood and caused the toxæmia manifested by the convulsion.

Later, however, it was shown that albumin occurred frequently in the urine of pregnant women, while the occurrence of eclampsia was comparatively rare, and therefore the direct and constant relation between albuminuria and eclampsia was doubted. On the other hand, the observed fact that convulsions sometimes occurred without albuminuria dispelled the belief that eclampsia is always toxæmic, while again, in other cases, albumin only appeared in the urine after the convulsions. This, then, is the cycle of facts which placed albuminuria during pregnancy among obstetric subjects which are at once interesting, important and difficult of solution.

The interest among physicians in albuminuria has undoubtedly arisen from its relationship to eclampsia. But since this relationship was not constant and since the existence of albuminuria did not always foretell the advent of eclampsia, nor, on the other hand, since eclampsia sometimes occurs unheralded by dropsy and albuminuria, it became necessary to study the subjects with a more extended view. Other theories, therefore, were demanded to explain the observed clinical facts.

It had been demonstrated experimentally by a number of observers that when the circulation of blood was interfered with in the kidneys that albumin appeared in the urine, and this was the manner in which the pregnant uterus, acting mechanically, was supposed to produce albuminuria. That such is the case and that this explanation is a sufficient one, at times, cannot be doubted; yet it does not explain those cases of albuminuria which occur early in pregnancy and before the uterus has had time to develop sufficiently even to fill the pelvis.

Halbertsma proposed the view that the ureters were compressed by the increasing size of the gravid uterus, and became dilated, and that in consequence of the impeded outflow of urine the kidneys became involved, especially where there was a disproportion between the size of the gravid uterus and the abdominal cavity, whereby tension and compression are produced. That other abdominal tumors are less often associated with albumin in the urine is explained by the fact that they do not develop in the same way as the gravid uterus within the pelvis, and therefore between the ureters.

In addition to these, other theories have been advanced. A super-albuminous condition has been spoken of, due to an inequality between the amount of albumin produced by the mother and consumed by the child. Reference has also been made to the increased arterial tension demonstrated to exist even in the early months. A potent factor, without doubt, is the increased amount of work demanded of the kidneys to excrete the waste materials derived from the two organisms.

In addition to these, it has been suggested that, in reflex nervous influences, albuminuria will find a frequent explanation. This view was first proposed by Tyler Smith, and has for its supporters many prominent men, and although it may appear vague and intangible, yet there are certain anatomical and clinical facts which give it weight and bespeak for it a not too hasty rejection. According to this view a sympathetic irritation occurs in the kidneys from the gravid uterus analogous to that which occurs in the mammæ and in

the salivary and thyroid glands. In addition to the reflex disturbances which may occur in any part of the nervous system already referred to, Frankenhauser has shown a direct connection through the sympathetics between the nerves of the uterus and the renal ganglia to the nerve terminals in the epithelial tissue of the kidneys. Added weight is also given in the researches of Holbrook concerning the nerves of the kidneys, in which is shown that the essential secreting structures of the kidneys are in intimate relation with the nervous system. Another somewhat related fact is that, in a case of ectropion of the kidneys observed by Buquet, the kidneys enlarged at the menstrual period.

Other views might be named, but the above have received the most consideration. That any one of them is correct to the exclusion of all others is probably not near the truth, since all the facts bearing on this subject and in its relation to eclampsia are not explained by any one theory. But it is probable that all the conditions indicated occur in certain cases or co-exist in various combinations in others. This would appear to be the correct manner in which to regard the whole subject, and is the only way in which conflicting clinical observations can be made to harmonize.

There is a question which opens up an extensive phase of the subject, and which, therefore, can only be indicated at present; namely, what is the relation existing between the clinical symptoms in certain cases and the kidney lesions permitting the occurrence in the urine of the various albumin forms now recognized? It is probable that further research on these lines will tend to elucidate certain clinical phenomena and also throw some light on the ever-recurring question of functional albuminuria.

So far, only albuminuria of renal origin has been considered in which it was presumed that there was no gross pre-existing renal lesion. If, however, the kidneys be already diseased, the pregnancy tends to aggravate the trouble, and, while it is not possible as yet to be very positive in our conclusions, it is certain that a peculiarly dangerous combination of untoward conditions exist, both as regards the life of the foetus (for abortion often occurs), and as regards the life of the mother. In these cases, while all do not have convulsions, many die or have their lives perceptibly shortened.

The present knowledge concerning this subject of the causes and the import of albumin in the urine during pregnancy leaves much to be desired. Many more clinical observations are required before the subject can be presented in the clear light which advanced medical science of to-day demands.

COMPARATIVE STATISTICS OF HOMŒOPATHIC AND ALLOPATHIC
TREATMENT.

BY CHARLES H. HADLEY, M.D., BROOKLYN, N. Y.

(Read before the Homœopathic Medical Society of the County of Kings, N. Y.)

RELIGION was kept back many years by the effort to twist facts to fit theories, and the same is true of medicine. As conscientious physicians, what we earnestly desire to know is the truth, and as a school I believe we wish to follow the light whichever way it leads. The view that is taken of homœopathy in one of the latest old-school works, Hare's *System of Practical Therapeutics*, is both interesting and instructive. Speaking of the various systems of medicines that have arisen, Dr. H. C. Wood says :

"Of these mediæval dreams there is only one whose survival challenges our attention at the present; this is the so-called homœopathy; the rallying point is the so-called law of *similia similibus curantur*; strange, is it not, that this alleged law which has made immortal the name of Hahnemann was not originally framed by him, but is plainly stated in the works of that truly great man, Hippocrates? for two thousand three hundred years this generalization has survived; it must possess some peculiar vitality, some measure of truth, and I myself believe that as a rule of practice it will at times lead to a good result."

The editor in a foot-note says that :

"The question of the causes of the survival of homœopathy is one of great interest. I believe the first successes of the practice were really due to the fact that the regular physicians of the day did more harm than good, while the homœopathic physician, giving only infinitesimal doses and thereby practically leaving his case alone, allowed nature full scope. This explanation does not apply to the present time; it seems to be true that homœopathy is everywhere on the decline, except in the United States and here it is probably holding its own; the reasons are multiple."

After stating several, he goes on to say :

"The most potent of all factors, however, is the notorious fact that the American homœopath does not practice homœopathy. Homœopathy has in fact practically ceased to exist; certain practitioners of medicine, however, avail themselves of the value of the name as a trade-mark in order to deceive the public and obtain an advantage over their rivals. The time has come, in my opinion, when the regular physicians should no longer, by refusing to consult with homœopathic practitioners recognize their separate existence; if consultations between homœopaths so called, and regular physicians became

frequent, in a short time it would be impossible to longer deceive the public; moreover the habit of truth-telling would have a very palpable effect upon the homœopathic physicians themselves; self-respect would soon lead them to tell the truth at all times. In my opinion the regular profession not only has it in its power but owes it as a duty to itself and to the public to announce once for all that homœopathy having ceased to exist, every physician is at liberty to consult with whomsoever he pleases."

If it is a fact that homœopathy has ceased to exist, then I am probably too late in presenting my statistics of comparative homœopathic and allopathic treatment, and this paper should properly be an obituary notice and be published after the funeral. I would cordially recommend my allopathic friend to take his own medicine, and a careful study of comparative statistics may lead him to still believe that his line of treatment may even now do more harm than good. His attitude toward the dear departed reminds me of an undertaker in a Vermont town who was directed to lay out in his best style one of the leading citizens who had as was supposed, passed on; after he had gone into the room a terrible uproar was heard inside. When the door was opened, he was asked: "What is all this noise about?" "I am trying to lay this corpse out, but he wont keep still long enough." The corpse had revived.

In getting comparative statistics of the effects of the two schools of practice it seems to me that if a community could be found where for a long period of time the treatment had been wholly under one school, and then for a long period under the same conditions under the opposite school of treatment, that the results should be shown by a difference in the death-rates. We have such a community in the town of New Shoreham, Black Island, R. I. It is an island 12 miles out in the Atlantic Ocean, with no contaminating land breezes or influences. It has been settled 225 years, and for the last 50 years the population has varied but very little from 1275 inhabitants, and the character of the population varied scarcely at all. There were no new families moving to the place or old ones moving away to any extent. Until 1872 the island was wholly under allopathic treatment; in this year a homœopathic physician settled on the island and in a few months the regular physician moved away leaving the island wholly under homœopathic treatment, and until 1884 the only treatment the inhabitants received was homœopathic. Since that time both schools have been represented. While the statistics of one year compared with another might not be as valuable, it seemed to me if a series of years was compared with an equal

period under the opposite line of treatment some results must be shown if there is any value in the different practice of medicine. I therefore took the records from 1862 to 1872, 10 years, wholly under allopathic treatment and found the whole number of deaths, 210, while in the 10 years from 1873 to 1883, wholly under homœopathic treatment, the number of deaths was 98, or less than one-half as many. In only 1 year did the maximum number of deaths under homœopathy equal the minimum number of deaths under old-school practice. The greatest number in any year under homœopathic treatment, 17; least number under allopathic treatment, 14. In order to carry out this study of comparative death-rate, I had copied from the records of the Board of Health in Brooklyn, a list of 6061 consecutive deaths covering a period of three and a half months. Taking the most accurate lists that I could obtain, the allopathic physicians in this city compared to the homœopathic are $4\frac{1}{2}$ to 1, but in signing death certificates during this period the ratio was $9\frac{1}{2}$ to 1, that is the number of different allopathic physicians was over nine times as many, while the death-rate was 1 to $15\frac{1}{2}$ or $15\frac{1}{2}$ times as many deaths under allopathic treatment as under homœopathic. To state it accurately the whole number of deaths were 6061. Signed by allopathic physicians, 5701; signed by homœopathic physicians, 360; whole number different allopathic practitioners signing death certificates, 870; homœopaths, 93. In using the word allopath I include every one who does not practice homœopathy, and that perfect justice may be done the self-styled regular school, the ratio is also given if the homœopathic practitioners equalled the regular school in numbers. As stated previously there are $4\frac{1}{2}$ times as many old-school physicians as homœopaths in this city. Therefore if the number under homœopathic practice is increased $4\frac{1}{2}$ times, the ratio between the number of deaths under each school will show the relative value of the treatment.

Diseases.	Old School.	Homœopathic.	Ratio if number of Homœopaths equalled the number of Old School.
Pneumonia,	935	58	$3\frac{1}{2}\frac{7}{9}$ to 1
Diphtheria,	153	15	$2\frac{1}{3}\frac{6}{5}$ to 1
Scarlet Fever,	170	15	$2\frac{1}{2}\frac{4}{7}$ to 1
Measles,	59	3	$4\frac{1}{2}\frac{9}{7}$ to 1
Croup,	147	6	$5\frac{1}{3}$ to 1
Typhoid,	21	3	$1\frac{2}{3}$ to 1
Children under 10 years,	2218	174	$2\frac{6}{7}\frac{5}{3}$ to 1

To place the result in a nut-shell, more than three times as many cases of pneumonia, more than twice as many cases of diphtheria and scarlet fever, four and one-half times as many cases of measles, five and one-half times as many cases of croup, died under old-school treatment, as would under the same number of homœopathic practitioners. Truly there must be something in a system that reduces the death-rate more than one half.

ARBORIVITAL MEDICINE.

BEING AN INQUIRY INTO THE CURATIVE POWERS OF SOME OF
OUR COMMON FIELD AND GARDEN PLANTS, JUDGED
OF BY THE DISEASES OF THE EAR.

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(Continued from February, 1898.)

IN proceeding to give the results of my investigation of the action of drugs, I do not wish to commit myself to any prearranged plan, and desire merely to state that facts will be given as they come in as much as possible in narrative form, and with such arrangement only as these admit of. Though dealing with ear diseases almost exclusively, the disturbances produced or removed in other organs of the body will be carefully and assiduously noted; this being, as I conceive, the scientific method of procedure in specialism. The idea is to give a case of disease, thought to be typical of the drug's action, that has been cured or in any way modified by such action and then if necessary to comment upon this and illustrate remark by less important experiences from time to time met with. For the sake of brevity the sthenogram, φA , after a drug will mean that one drop of the arborivital tincture has been given and that this has been allowed to act till the next mentioned date; if the dose has been repeated frequently this will be distinctly stated, though of course *ipso facto* the remedy will then cease to be arborivital. The tinctures I use have been made by myself, except a few of the early ones which were medicated expressly for me, from my own specimens, by a trustworthy chemist, and it is to be remembered that they are not by any means the strongest in material ingredients that can be prepared, while to

some of those, many times used, additional alcohol has been freely added from time to time to prevent evaporation. All I aim at in the preparation of a tincture is to secure and preserve the growth-force, and to prepare the tincture in such a way as to leave as little doubt as possible about its presence. For this reason I advocate the preparation of arborivital tinctures in the field from the living plant, the preparer carrying with him a small phial, into which the budding stalk and young leaves of the plant are placed fresh as they grow, and upon these, simply crushed between finger and thumb, the rectified spirit should be poured. But more than this, in order to further increase the efficacy of the tincture and to secure with even greater certainty the power of the growth-force, I am in the habit of plunging the living stalk, while yet connected with the plant, into the spirit, and allowing the strongest daylight that usually plays upon the plant in its native habitat, to fall upon the phial filled with the spirit, the stalk being at the same time immersed in it. Thus our tinctures are presumably potentized, and each potentization will represent five minutes exposure. When the branches are thus subjected to the spirit and the daylight for an hour, I find the branch and its leaves have in most cases withered; at the termination, therefore, of each twelfth potency a fresh branch or stalk should be chosen and subjected to the same process. A number before the sthenogram will therefore indicate the potency, thus: *Plantago lanceolata* 12, φ A, will be *plantago lanceolata*, 12th arborivital mother tincture. Such 12th and 24th potencies I have used pretty extensively, and believe that thus potentized the remedy has a more certain curative influence.

To say that such preparations are stronger than others, as has been claimed for the homœopathic dilutions, would require a definition of the word stronger, and I therefore avoid this statement purposely; all I commit myself to is that tinctures thus potentized represent powers different from those prepared in the ordinary way, and that their curative properties are, as far as I can judge from clinical experience, more certain. The arborivital tinctures will, therefore, be potentized directly from the plants as they grow, and are hence, to coin a word, termed *heliosthens*, and a drop of a high *heliosthen*, say 12 or 24, will mean a drop of as definite material strength as it is possible to obtain from a plant by the action of rectified spirit upon it, plus any strength communicated to it by our method of potentizing, and which of necessity is of purely hypothetical quantity. At the same time the force associated with the material parti-

cles of the plant, the original growth-force, and the force derived from potentization by means of exposure of the living plant in spirit will represent as nearly as possible, each of them, a definite power, which in contrast with ordinary homœopathic preparations is in every way a gain.

Agraphis Nutans, vel *Hyacinthus Nutans*, vel *Hyacinthus Non-Scriptus*, the common bluebell of the woods, natural order Liliaceæ.

Tincture made with rectified spirit and juice of the budding stalk and young leaves, March, 1892.

This remedy which was one of the first that engaged my attention and which has continued to interest me more and more every day, possesses an action that seems in every way definite and distinct.

The plant itself has at all times been a favorite; one of our earliest spring flowers, it brightens and lends color in the early year to our faded woods. The bluebell shades itself in shrubberies, and while nestling close to the wood-anemone takes care to be well shaded by the smaller hazel twigs, beneath which it is so often found, from the cold easterly breezes.

Its action as a remedy finds remarkable illustration in the case of a little girl of five years of age living at Brixton, who was admitted under me at the L. H. Hospital June 11, 1892, with deafness and otorrhœa of both ears, dating twelve months back, and a history of three bad attacks of bronchitis; one at a year old, second at two years, and a third at three. Her eyes and nose discharged profusely and had to be bathed every morning.

The little girl has always been subject to cough, and for four or five months has been bringing up dark gray mucus. Bowels are regular, appetite poor, pines constantly and perspires much in bed; watch distance not taken.*

Agraphis Nutans, φ A. — June 25, 1892, altogether better but has some hacking cough with beady phlegm first thing in the morning, discharge much less from both eyes and nose. S. L., 2-3 a day.†

August 6, 1892.—Once during the interval a discharge, vaginal in situation and catamenial in appearance, was noticed but did not continue. In every possible way the child has improved; hearing much better, the eyes and nose no longer require bathing, and though discharge is still seen it is very much less.

* I find it useless to test the watch hearing of children under six years of age, their answers are so misleading.

† *Saccharum lactis*, two pills thrice daily *et seq.*

Agraphis Nutans, $\varphi A.$ —This was the patient's last attendance, a cure having, with scarcely a doubt, been effected.

The case is in every way characteristic of the remedy, a tendency to free discharge from mucous membranes, a relaxed condition of the system generally and a proneness to take cold on exposure to cold winds. Its action certainly reminds us of *scilla maritima*, next to which it is usually described in works on botany, both being of the same natural order, the *liliaceæ*.

I have seen, however, sufficient of the action of the remedy to convince me that there are strong points of difference between the two, and that in the bluebell of the wood we have a remedy for children which in some points is of extreme importance. Bear in mind the improvement above recorded resulted from a single dose; the occurrence of vaginal discharges while under the influence of the remedy is very interesting, for more than once I have observed irregularities in this sphere of the organism to be modified by it. There was no change of diet or mode of living whatever, and a like remark applies to all cases unless otherwise stated.

Another case we may mention is that of a girl $\text{æ}t.$ $5\frac{1}{2}$ years, for whom on the 10th September, 1892, *agraphis nutans* was prescribed. She had had sore throat a week ago leaving profuse discharge from the left ear with deafness, the child's general condition being feeble. On the 24th September, improvement in every way was recorded, child every way stronger and better, ear discharge much less and deafness apparently gone.

In the case of a girl of 12 where post-nasal growths and enlarged tonsils had followed upon diphtheria some six years previously, a single dose of *agraphis nutans* was followed by a lessening of the symptoms, viz.: talking in sleep, mouth open, fulness of the tonsils, twitchings of the nose, loss of smell, recurring colds in the head; and improvement has continued under the same given at intervals of several weeks.

A governess of 30 admitted the 10th September, 1892, very deaf in both ears for five years, with hissing tinnitus, cause unknown, very nervous and weak, easily tired, constant headache across the forehead and bridge of the nose, aggravated by high winds (has just returned from sea voyage which in every way made her ears worse), dry feeling and burning in the throat, monthly period followed by profuse leucorrhœa, no pain or backache. M. Ti.* natural, watch distance R. $\frac{1}{2}$ in., L. not contact, *agraphis nutans*, $\varphi A.$ October 1st,

* *I.e.*, membranæ tympani.

1892, much improved, tinnitus less, head lighter, deafness appears less, and a symptom which used to trouble her a good deal, viz.: cracking in the head when bending down as if a bell were ringing, is much less. Leucorrhœa is certainly very much less.—H. D. R., $\frac{1}{2}$ in. L. C.

Another case that is interesting as pointing to the action of *agrapis nutans* is one to which my attention was called a few weeks ago. A young lady who had been my patient as an infant, but who has now arrived at the interesting time of 15, has suffered nearly all her life from enlarged tonsils with post-nasal growths; so much so that some years ago I advised their removal. After this she fell into the hands of other practitioners, one of whom is a specialist in throat affections; he too advised removal. At this juncture her mother wished me, as I had known her in her infancy, to again see her and pass an opinion upon her case. I strongly dissuaded them from proceeding to operation and sent one drop of the *agrapis*; at the end of the first fortnight the report was improvement, but nothing very distinct, especially as regards the tonsils; another drop was then given and at the end of the second fortnight the report was, undoubtedly improvement has taken place in every respect; the tonsils are much smaller and in every way the throat feels more comfortable.

In quite a large number of cases I have seen evidence to convince me that chronically enlarged tonsils can be modified in size by the *agrapis nutans* given as I recommend.

But of all of the conditions that are to be met with, there is one in the treatment of which the *agrapis* stands forth unrivalled and as far as I know inimitable. This is in the treatment of the mutism of children. When a child rising to 4 or 5 years of age is unable to speak, especially if unable to drink properly, and if along with this it is found that his hearing is perfect, there is one remedy which in every way gives reason for encouragement in the treatment of such a case, and this is *agrapis nutans*. A mute child incapable of drinking or of closing the jaws properly is almost certainly the victim of post-nasal growths, but along with these growths it will be found that all the glandular structures connected with the buccal and nasal cavities are imperfectly developed and are presumably interfering with the muscular action of the jaws; if the child dribbles this will be all the more indication of its condition; for such a child we can prescribe the *agrapis nutans* with greater probability of success than any other remedy that I know of.

There is at present attending the hospital a young, finely developed man, a deaf-mute, who retains a slight amount of hearing and a slight power of speech. To this man I gave a short time ago one drop of the agraphis and the testimony of those about him was that most unmistakably his power of speech improved immediately afterwards. This perhaps is not saying much, but to me it shows that the remedy at least pointed in the right direction.

And when, side by side with this case, I treated a little deaf-mute three years old that dribbled from the corners of the mouth, and when in the course of a few weeks after a dose of agraphis, I found that this dribbling had entirely ceased and that the general condition and even the hearing of the child had improved, I could not help feeling, taking all my experiences into consideration, that we have in agraphis a valuable remedy for mutism. The action of the agraphis upon deafness is apparently not direct, but is secondary, acting upon the glands connected with the orbit, the nasal cavities, the pharyngeal and buccal mucous membranes; hence it is mutism, not so much *deaf-mutism*, for which I would specially recommend it. In addition to this, the agraphis exerts an action, which at present is undefined, upon the head, clearing and strengthening the memory, often removing tinnitus, and besides this it has an action, also quite ill-defined at present, upon the ovario-uterine sphere of the organism.

As additional clinical experiences corroborative of these statements will naturally be called for, I give short notes of cases: "A man of about 45 years, who was inclined to general plethora, due in a great measure to continual tippling, and who suffered from constant hissing tinnitus, varying very much, with tendency to tough phlegm in the back of the throat and congestive headaches, reported decided relief after one dose of agraphis."

"Youth, æt. 19, nose always full of discharge, noticed on blowing it; decided relief from one dose."

"Deafness, nine months' duration, in a woman of 70, with tendency to running from left nostril and fulness of tonsils, unable to hear in a noise, and loud talking confuses, east wind renders ears sensitive and induces neuralgia in the teeth and gums; in this case the hearing returned two days after one dose of agraphis. The reality of the influence of the agraphis is open to doubt in this case, as these obstructive, catarrhal, tubal deafnesses come and go suddenly and with great irregularity. Still the agraphis was well indicated."

"In a girl of about 19, with deafness and stoppage of the nostrils; a week after a single dose, nose went discharging all day and after this, stoppage of nose and hearing improved."

"A girl of 18, being treated for congested turbinated bones with blocked nostrils and, in whom the catamenia came too soon and hung about with yellowish discharge in intervals, the period came quite regularly and discharge ceased after one dose, and later on her mother noticed her tonsils smaller."

"Sickness and great pain in the pit of the abdomen at monthly period which latter was unusually copious and only lasted a day, since then quite well, but next period missed, and memory is bad; had never before had irregularity, though her age, 43, is suspicious."

"Deafness, twenty years, and tinnitus in a man of 53, with weakness of voice and phlegm in back of nose, tendency to take cold and feverish towards midnight and chilly in the morning; all these symptoms improved after one dose, though the improvement in the hearing was but slight."

"Discharge from nose gone and throat much clearer.—(Hospital patient's report)."

"A lady of 32 who complained of plugs of phlegm continually rising in her throat found great relief after one dose."

"Harvey H., æt. 22, clerk to the School Board of London, deaf since childhood; treated without benefit at a neighboring ear and throat institution, came to L. H. Hospital, October 8, 1892. H. D. R., 20 in.; L. 14. R. m. ti., cicatricial scars. L. m. ti., hidden by dry discharge; some post-nasal growths. Agrap. nut, ϕ A. October 22, 1892. Hears better certainly; nose stopped more than usual, left ear discharging freer. R. 50 in.; L. 40 in.—S. L., 2-3 a day."

This ends our clinical experiences with agraphis and almost all point to its being essentially a catarrhal remedy, acting as before stated upon the throat, nose, eyes, ovario-uterine and cerebral regions and the glandular apparatus connected therewith.

WERNICKE'S HEMIANOPIC PUPILLARY INACTION.—Leyden (*Neurol Centralblatt*, August 15, 1892) has met with a case in which the localizing value of this sign was confirmed by necropsy. The patient, aged 69, had left hemiplegia with right homonymous hemianopia. On illuminating the right half of either retina, the pupil remained unchanged. When light was thrown on the left half of either retina, marked contraction of the pupil occurred. In the right lenticular nucleus a fusiform patch of softening was found extending into the cerebral peduncle, and partially involving the optic tract.

MALINGERING AND ITS DETECTION.

BY CLARENCE BARTLETT, M.D., PHILADELPHIA.

TEXT-BOOKS bearing on practice of medicine, and even special treatises pertaining to most branches of medical science, have but little of any importance to say concerning malingering, and yet this subject is one of great practical interest. True it is that instances of simulated disease are not frequently observed in general medical practice, still they do occur, and then if the physician is caught in the trap set for him, the mortification that ensues is, to say the least, decidedly uncomfortable. Unmindful of the deceived practitioner's many successful battles with genuine disease, his error is utilized by neighboring gossips to hold him up to ridicule. The necessity of being on the watch for feigned disease is therefore evident, for no one knows at what moment such cases will come to him.

When disease is simulated, the culprit always has some object in view. Even children are known to practice deception, usually to avoid irksome tasks at home or at school. How often do we hear of headaches conveniently appearing at about 8.30 A.M., and disappearing with still greater convenience at 9.15 A.M. ! Even blindness may be assumed by the more precocious youngsters. I can recall such a case coming to the eye department of the Hahnemann College Dispensary in 1880, and who stated that he was blind in one eye, a blindness that was at once shown to be assumed by Dr. William H. Bigler, whom it was my pleasure and profit to assist at that time. Among adults, symptoms are assumed for the purpose of calling forth sympathy, to secure support while living a life of idleness, to gain entrance to hospitals, to avoid punishment, and last but not least, to secure damages for alleged injuries.

This latter class of cases is of especial importance to the profession. In our dealings with them we owe a two-fold duty, one to ourselves and the other to the general public. We owe a duty to ourselves, because under no circumstances should we connive at fraud ; because the malingerer will never entertain the slightest respect for the scientific attainments of the physician he deceives ; and because if the malingerer is unprincipled enough to take money for fictitious damages, he will not hesitate to defraud the physician whom he has deceived. We owe a duty to the general public to do all in our power

to aid and not to defeat justice. Every man who seeks damages for injuries received must prove the extent of the alleged injuries. His physician should put him through every possible test to prove that they are genuine. If this is done, and the facts stated are borne out by the examination, then the plaintiff's case is only made stronger; if, on the other hand, the case is so weak as not to bear rigid scrutiny, the sooner all concerned are rid of it the better. An illustration of the flimsy pretexts on which lawsuits may be based was instanced a few years ago when one of our prominent physicians was sued for an enormous sum of money by his driver on account of alleged injuries received in a runaway accident. It so happened that this driver applied for treatment to me some time before beginning suit at the dispensary of the Hahnemann Medical College. The symptoms disappeared promptly, and finally he reported himself as cured. But one week later he secured the services of a lawyer, and entered suit as above stated. Although the suit was lost, the defendant physician was put to an expense of over one thousand dollars in lawyers' fees and loss of practice, to say nothing of anxiety and annoyance, and all because of a pettifogging lawyer and a worthless vagabond. In this case expert medical testimony was brought forward to show the extreme probability of a future epilepsy; in fact, I am not sure but that the expert(?) swore that an incurable epilepsy was certain to appear.

The extent to which malingerers will go to gain a point is oftentimes wonderful. When a student at the Hahnemann Medical College in the season of 1878-79, a remarkable case was brought before the class by Prof. B. F. Betts. It was that of a young woman who alleged that she was a confirmed masturbator. Disgusted with herself, she had determined to reform. To aid her in this determination she had placed a number of pieces of glass in the vagina, believing that titillation of the parts would thus be made to occasion pain instead of pleasure and force her to desist from the pernicious practice. I remember the surprise of the class at the large quantity and the rough angles of the glass removed by Prof. Betts. The following week we were informed that the girl was an arrant fraud; that she was what is technically known as a "hospital bummer;" that she had been practicing successfully at other hospitals the same scheme that she had tried with us; and that she had interested a large number of sympathetic women who had been doing considerable for her welfare.

Medical literature contains numerous other instances more remark-

able, to the extent of being well nigh incredible. In the *Medical Record*, vol. xlii., p. 726, is reported the case of a hysterical (?) patient who underwent laparotomy for the fourth time. The reputation of the physician reporting the case, Dr. J. D. Bryant, is a sufficient voucher for the authenticity of the facts presented.

The patient was a young women of 22 years, who stated that she had had inflammation of the bowels three times. Each of these attacks began with pain in the left iliac region, was followed by chill, fever, and vomiting of blood, and attended with bloody stool. Each attack led to laparotomy. About two months before her admission to Bellevue Hospital, the pain began again in the same situation, and was attended with chill, fever, vomiting of dark colored blood, and the passage of bloody stools. Examination on admission disclosed general abdominal pain and tenderness, attended with fæcal vomiting, and bloody and mucous stools. On the evening of her transfer to the surgical wards it was reported that she had vomited a portion of a glycerine enema eighteen seconds after its administration. In order to be certain of the identity of the vomited matter, the resident surgeon had given a second enema which contained methyl violet. A portion of this was vomited in fifteen or twenty seconds after administration. "As the expulsion by the mouth so soon after administration could not be accounted for rationally at that time except on the theory of the presence of a large fistulous communication between the sigmoid flexure and the stomach or the colon and stomach, directions were given to prepare the patient for operation to be done the following day." The operation was accordingly performed at the earnest solicitation of the patient. General adhesions were found, but no fistulous communication anywhere could be discovered. To make assurance doubly sure, the stomach was opened and examined carefully by every possible method. The patient recovered from the operation, though with a fæcal fistula. During convalescence she developed hysterical symptoms, as great excitement, attended by violent crying, complete ptosis. Finally on May 9th she complained of great abdominal pain, continuous retching attended with fæcal vomiting. "For the ensuing six days she was nourished entirely by the bowel. On the first of these days, the vomited matter had the odor of whisky, and possessed other characteristics strongly suggestive of the nature of the nutritious enemata that were being administered every few hours. On May 12th at 5 P.M., her temperature was normal by the mouth, while by the rectum it was 113°." On the following day the rectal temperature was 108°; but after dilatation of the sphincter ani and carrying the thermometer well up into the bowel, it was but 99°. During the six days of rectal alimentation, continuous fæcal vomiting, and the occasional high temperature by the rectum, the patient's general condition, pulse, and the temperature elsewhere than in the bowel were normal, and for this reason it was

believed that the patient was obtaining food surreptitiously elsewhere. "As she still continued the vomiting of matters resembling the enemata, an enema of eosin solution flavored with oil of cloves was given by the house surgeon, and fourteen minutes later was expelled by the mouth an ounce of the mixture. Still it was fifteen hours after the giving of this enema before any evidence of it appeared at the fistulous opening in the abdomen. On the following day she was stripped while in bed and removed to the corner of a neighboring ward, and there placed in another bed, her hands tied, and continuous watch placed over her. She was then given as before methyl blue flavored with oil of cloves." No more fæcal vomiting occurred notwithstanding her efforts at retching, which were soon discontinued. The nutritious enemata were continued as before. She soon begged for food, which was given her and the enema discontinued. From this time she made a continuous and prompt recovery. The following statement regarding the deception was then obtained from the patient: "1. She knew that she was doing wrong, but the impulse to do so was irresistible. 2. That in the first instance (glycerine enema) she fooled the nurse by removing some of the enema from the rectum with the finger and placed it in the mouth, then while being observed, retched and expelled it from the mouth with apparently great effort and suffering. 3. She obtained the methyl violet while it was in a dish placed on the stand by her bedside, when the nurse was stooping down to place a vessel on the floor. Therefore she had it in her mouth ready for exhibition before the injection was given. 4. During the six days of continuous fæcal vomiting and the phenomenal high temperatures and rectal alimentation (all of which caused no well-marked physical change), she was well fed with milk by a patient of the ward during the absence of the nurse. The fæcal supply of the vomit was taken from the abdominal fistula, put in the mouth by herself, and kept there to be expelled while under observation. 5. Portions of the clove-scented eosin solutions used as an enema were removed from the rectum by the patient with her index finger, put in the mouth, and expelled when necessary for the purpose of deception. 6. She refused to account for the high registration of the thermometer, saying, 'I do not know.'"

Dr. Bryant's paper closed with the report of another case of remarkable deception practiced by a patient of Dr. J. M. Leslie, who removed from her hand over three hundred fragments of bone, apparently of chicken-bone that had been boiled. The pieces ranged from seven-eighths to two inches in length. Some few had been whittled down to facilitate introduction.

In the *Medical Press and Circular*, September 17, 1890, appears a short article entitled "Curious Malingering," from which I take the following:

One of the plans to which prisoners in the gaols of India resort for the purpose of securing their release is that of causing a fictitious form of dysentery. The symptoms are kept up by the convict taking surreptitiously an irritant of some kind, which has the effect of producing dysenteric symptoms. It is said that this habit is persisted in occasionally until death ensues. Another curious habit has been revealed; namely, that of lowering a leaden bullet to the level of the epiglottis and leaving it there for a short time daily. It is said that the effect of this is that a pouch is sometimes deliberately formed in the pharynx, and this pouch often becomes large enough, at the end of six months, to hold several rupees. A secret receptacle of money is then at the disposal of the enterprising individual. In the gaol of the Presidency of Calcutta is a bullet measuring three-quarters of an inch, which is known to have been used for this purpose.

This report certainly tries the credulity of the reader.

In the *Medical Record*, vol. xxii., p. 277, Dr. Thomas F. Houston reports a case of malingering ending in a very serious surgical operation:

The patient was a colored man accused of stealing a watch, who became apparently insane. He was convicted and sentenced. On being returned to jail, he jumped up, struck his heels together, and remarked: "Well, I am guilty; but I would have fooled the law but for that d——d doctor." In one hour he had torn off his clothes, thrown them out the window, and was acting wildly again. After this he did not speak nor get out of his bed, which emitted a horrible odor from the excretions he had passed into it. An examination then made found four large blisters, two on each ankle, about two inches in diameter, occupying the site of some old shackle-marks. These were evidently the effect of two cold nights which had occurred during the time that he was attempting to play the madman. The prison authorities could not induce him, by threats or persuasion, to show the slightest sign of human intelligence, so they had to let him lie in his filth. One week later gangrene of both extremities had set in; temperature, 103° ; pulse, 120. Both feet had to be amputated. The patient recovered. He afterwards expressed gratitude to his physician for the attention, and admitted that he had been malingering.

I now proceed to consider the various symptoms frequently simulated, and the means for their detection:

I. *Paralysis*.—Paralysis may be feigned as a means of proving the existence of an incurable spinal or nerve lesion. One is first led to a suspicion of malingering in these cases by a process of exclusion; that is to say, the symptoms present are not consistent with

those of any possible lesion. The distribution of the paralysis does not accord with certain other phenomena; the various reflexes are normal; muscular rigidity or atrophy is absent; electrical reactions are unaltered. I believe that the study of the deep and superficial reflexes in these cases is of the utmost importance, for in the vast majority of cases of paralysis, perhaps in all, these will show some departures from the normal standard. The presence of normal electrical reactions is not of much value, as many forms of paralysis may exist with this condition.

When one of the legs is said to be paralyzed, careful observation of the way in which the patient uses his stick should be made. It will be found that he does not always use it so as to relieve the injured member.

When one member is alleged to be completely paralyzed, anæsthesia is probably the best means of detection. While going under the influence of the ether, the patient will more than likely struggle, and the movements will involve the paralyzed (?) as well as the normal extremities.

II. Epilepsy is frequently simulated, generally, however, to secure the sympathy of bystanders. Skilled malingerers have been known to deceive the most expert diagnostician. Fagge, in his work on the *Practice of Medicine* (vol. i., p. 710), relates that Esquirol, who did not believe that an attack could be simulated so as to deceive, was once talking with Calmeil over the possibility of this deception, when the latter fell on the floor in violent convulsions. Esquirol examined him for a moment and then said: "Poor fellow, he is epileptic." Thereupon Calmeil got up and asked him whether he still retained his opinion. This shows the possibility of perfect simulation.

During the convulsive seizures themselves, certain tests may be applied. During convulsions the pupils are dilated, and do not respond to light. This symptom is usually regarded as conclusive evidence of the nature of the attack. Care must be observed, however, in looking for it. The great muscular exertion required in simulating a convulsive seizure will likewise cause dilatation of the pupils. In the latter case, however, they respond to light.

Fagge has suggested a very efficient means of exposing impostors who choose to simulate epilepsy, namely, the blowing of snuff into the nostrils. This will produce irresistible inclination to sneeze if the attack be a feigned one.

Supraorbital pressure is likewise a good means of detecting malingering.

The character of the convulsive movements, their times of occurrence and modes of onset, afford important diagnostic aids. About six months ago a man, aged 26 years, who had once been examined in the Department for Nervous Diseases, Hahnemann College Dispensary, subpoenaed me to testify in his behalf. He had committed forgery, and it was his intention to prove that the crime was committed in a post-epileptic trance. His case was called for trial on several successive days, but he always succeeded in getting a convulsion at some convenient moment. The seizures consisted of tremulous or clonic movements on one side, and hysteroid movements on the other. They were not preceded by any tonic stage. Evidence of their oncoming was discernible for quite a period beforehand, and his falling was gradual, so as not to hurt himself. He had had convulsions at very convenient moments for the accomplishment of his nefarious purposes. He did not bite his tongue. His defence availed him nothing, and he was convicted and sentenced to three years' imprisonment. It was a plain case of malingering.

III. *Pain, rheumatic, neuralgic, etc.*—Pain is frequently made the basis of damage suits. The inference on the part of the malingerer is that the symptom, being a purely subjective one, is capable of perfect simulation. Associated symptoms will oftentimes be of great avail in exposing the correct nature of the case. In simulated pain we have, however, some important objective tests. When the patient complains of sensitiveness to touch over the painful part, it is usually sufficient to distract attention while pressure is made. This method was successfully employed in the case of Nora G., to be described shortly, and by Dr. C. M. Thomas, in a hospital case seen by me when acting resident physician in the Philadelphia Homœopathic Hospital in 1879. The latter patient had been admitted for the treatment of sciatica. Her sufferings were excruciating. She kept all the other patients awake by her cries. Treatment was unavailing. Distracting her attention by examining her spine and then making pressure over the sensitive spot showed that the pain was assumed. The object in practicing deception was to gain a shelter, for the constable had just seized the entire household goods and put her out of her home.

Observation of the pulse during a paroxysm of pain will furnish some aid. The pulse should be quickened at such times if the sufferings be genuine. When sensitiveness to touch is a symptom, then increase in the pulse-rate at the time of making pressure will be noted.

Genuine pain, if at all severe and long continued, influences nutrition and sleep; simulated pain rarely exerts that effect, unless accompanied by persistent efforts on the part of the patient to bring on a state of malnutrition by improper living.

In many cases in which pain is the source of complaint, and in which the pain is aggravated by any movement, it will be observed, when the facts stated are true, that the muscles about the painful part exhibit a certain amount of rigidity. This was exemplified in a case recently examined by me, in which there was every incentive to dissimulate. The pain was in the lower portion of the back and followed a railroad injury. On stooping it was observed that the back muscles became rigid, and this rigidity was accompanied by a clonic movement of the back muscles.

IV. *Anæsthesia*.—(One of the most commonly given reasons for believing that a patient has lost sensation is that he is able to stand having a needle run through his flesh without giving any evidence of pain. This is a fallacy, for almost any one can, with very little training, accustom himself to such a procedure. As positive evidence of genuine anæsthesia, as a means of detecting malingering, it is worthless. I have heard it said by a prominent surgeon that there is no reliable test for simulated anæsthesia. With this statement I disagree. Probably the best course to pursue in examining such cases is to first examine the condition of sensibility after the various methods employed in regular practice. This over, various control tests may be made to confirm the first observations. Blind-fold the patient. Test the sense of touch by bringing the test object first from the periphery to the centre. Mark with an aniline pencil the point where it is first felt. Then repeat the experiment by bringing the object from the centre to the periphery, and then mark the point where sensation is lost. Notice if the two observations agree. I doubt very much the possibility of any malingerer being able to deceive with this test.

Electricity may be called into service when there is a fairly well-defined line of demarcation between the areas of sensibility and anæsthesia. Having determined this line, place a plate electrode (it must be a perfectly flexible one) immediately over the line. Of course the patient then feels the current. Then, without the knowledge of the patient, raises that portion of the electrode from the side which covers the sensitive area. If he still feels the current his anæsthesia is simulated.

A study of the pulse may be made for the purpose of detecting the

genuineness of the loss of sensation. Apply a faradic brush to the affected part, making the current up to the endurance of the patient. Having determined this point, take the patient's pulse, first while no current is being passed and while the electrodes are in position; and then, again, when the current is suddenly turned on. If he complains that he does not feel the current and yet at the moment it is turned on his pulse quickens, I think one is safe in declaring the patient a fraud.

V. Aphonia. Loss of voice is sometimes simulated. The only reliable means of detection with which I am acquainted is anæsthesia.

VI. Blindness. When monocular blindness is assumed, detection is as a rule an easy matter. Placing a prism before one eye produces double vision. A modification of the old prism test is the use of the Maddux prism. This, if blindness is simulated, produces treble vision. Still another modification is the rod and stenopaic test. With this over one eye, and the patient looking at a flame, there is formed an image consisting of the normal flame with a line of light running through it. Some patients may be too shrewd to be caught by the above schemes. Then the old color test may be employed. I cannot better explain this test than by quoting a case reported in the *Medical Record*, vol. xxxi., p. 424.

In a large factory a workman wielding a hammer carelessly allowed it to slip from his hand. It flew across the room, striking a workman in the left eye. The man brought suit in the courts, and although an eminent oculist after an examination declared that no apparent injury could be detected, claimed that his eyesight was destroyed and refused all offers of compromise. On the day of the trial a further test was made. The oculist for the defence had a pair of glasses made, the right eye being of red, and the left of ordinary glass. He brought also a black card with a sentence written on it in green ink. The plaintiff was ordered to put the glasses on and read the sentence, which he readily did, thus proving himself a perjurer, as the sound right eye being fitted with a red glass, could not distinguish the writing.

For the successful application of this test it is absolutely essential that complementary shades of red and green be used.

When absolute blindness of both eyes is complained of, detection is not always an easy matter. In such cases one is obliged to rely upon the conditions associated with the blindness as its mode of onset, state of the pupils, ophthalmoscopic appearances, condition of

the deep reflexes, and the presence or absence of other symptoms. Possibly the best test of the blindness is that suggested by Dr. H. I. Jessup, and is as follows: Have the patient face the physician, with his eyes wide open. Then slowly approach one eye with a sharp-pointed instrument. Do this very slowly indeed. When the point comes within a quarter of an inch of the cornea there is an irresistible inclination on the part of the patient to draw the head away. This will not be the case, if the patient is blind. This test I put to successful application at the hypnotic performance given before the World's Convention at Atlantic City in 1891. I with others was invited to the stage to attest the genuineness of the phenomena displayed. The patient having been hypnotized I was invited to plunge a long sharp needle into his flesh. This I declined to do, but instead made use of the above test. The patient gave evidence of seeing it. He stood the ordeal for a time, and then moved the head back. The operator declared the test an unreasonable one as it was too severe.

Two years ago, I was invited by Dr. G. M. Christine to see Minnie, æt. 16 years. She was a bright looking rather prepossessing girl. Two days before she had fallen down a few steps, shortly after which she became absolutely blind. Ophthalmoscopic appearances were normal. Her pupils reacted to light. Knee jerks were normal. There was no paralysis or pain of any kind present. Aside from the blindness she was without a symptom. Although there was no apparent incentive to deceive I gave the opinion that the patient was malingering. The case was subsequently brought to the Hahnemann College Dispensary where she was seen by Drs. C. M. Thomas, H. I. Jessup, and others, all of whom concurred in my opinion, though unable to conclusively trap the girl. A few days later, I brought her before the class, and then applied the knife test, which caused her to move her head, she claimed (though incorrectly) because I touched her cornea. In taking her from the clinical amphitheatre over to the eyeroom, Dr. George P. Stubbs (then a resident physician), who was leading her observed that when she came to a step, she lifted her foot properly as if her vision was perfect. In a few days vision began to return, fortunately for the physicians in one eye first. The prism test gave double vision. At five feet she read 5-200; bringing the test-type nearer vision increased to 3-20. When leaving my office she without the slightest hesitation put forth her hand to take hold of the door-knob. From this time on improvement was rapid, and sight was entirely restored.

Recent investigations into the history of this case have revealed the fact that the above incident was apparently the beginning of a downward career. The girl stole things from her home, ran away a couple of times and went on the stage, became pregnant and had a miscarriage. She still claims that her blindness was genuine. It seems that her vicious conduct began two years before the attack of assumed blindness. In the opinion of all connected with her, her malingering was for the purpose of escaping punishment for some wrong-doing in which she had been detected.

One of the most interesting cases of malingering ever my lot to witness was that of Nora. The interest centres in the variety of phenomena simulated, the persistence with which she carried them out, and the trouble to which they gave rise. On December 10, 1889, this patient presented herself to my department in the Hahnemann College Dispensary. She brought a note from Dr. Charles M. Thomas stating that she had eye symptoms which were fraudulent, and requesting an opinion concerning certain nervous symptoms. The history she gave was as follows: Some time before, she had been struck on the forehead over the left eye by a screw-eye of a swinging door at one of our railroad depots. The wound did not heal rapidly, but suppurated. Shortly before coming to us for treatment, the vision of the left eye was completely lost. She claimed to be unable to see anything. She also suffered from frightful neuralgic pains over the seat of injury. The affected spot was so sensitive to touch that she could not tolerate even light pressure. While in the eye-department her eyes were examined thoroughly. Ophthalmoscopic examination gave negative results. The pupils reacted normally. A Maddux prism placed before one eye, made her see three objects; a prism before the right eye and a red glass before the left gave two images, one red and the other white. She was then sent to me for examination. Directing her attention to the spine and making a feint of examining the same, I then made pressure over the sensitive point on the forehead. She did not then wince a particle. *Saccharum lactis* was prescribed. She returned for treatment from time to time. On one of her visits, I had her sit in a position where she could see me examine a case of locomotor ataxia; on examining her later, she had instability when her eyes were closed. On February 3, 1890, she reported to Dr. Weston D. Bayley that she had been obliged to leave Sunday-school the preceding afternoon at 3 o'clock, and that she went home and went to bed, and was unable to get up until the following morning. By a

singular coincidence, Dr. Bayley had seen her enter her home at 9 o'clock that same evening, thus exposing the falsity of her statements.

December 30, 1890, she turned up again, this time in the Hahnemann Hospital. That evening she was attending a Christmas festival when she was taken in convulsions. Two physicians who happened to be present brought her to the hospital, when she was placed on the couch in the receiving ward. While the attention of Dr. Stubbs, one of the resident physicians, was diverted she came out of her spasm and began to inspect her new quarters. While thus engaged he turned suddenly and detected her. She went into convulsions again. From these she was aroused by the application of supraorbital pressure.

On my visit to the hospital the next morning, the admission of the patient was reported to me. It was then arranged between Dr. L. L. Lazear (one of the resident physicians) and myself that I should give an order that her spine should be cauterized and that Dr. Lazear should make a feint to carry it out. I found the patient in bed, apparently in a stupor. The genuineness of this stupor was made very doubtful by constant blinking of the eyes. The order for actual cautery to the spine was given. After I left, she gradually came to, and then sent for the supervising nurse, whom she asked whether or not she had been dreaming; it seemed to her that she had heard some one order her to be burnt. On being told that it was a reality, that she was to be burned, she ordered that a message be taken to the doctors to the effect that she was better, and would like to go home. She was accordingly dismissed. I heard nothing more from her until one morning I saw in the papers that a sympathetic jury had given her \$5000 damages. The above evidence later coming out, the defendant was given the privilege of a new trial.

As I write this, I am made acquainted by Dr. Charles M. Thomas of another very simple test for simulated monocular blindness. Direct the patient to read aloud. While he is doing this hold a penholder or pencil before the eye which he claims to be sound. If the blindness be genuine, vision will be interfered with. If vision exists in both eyes, the patient will be able to read perfectly.

VII. Deafness. The detection of complete deafness of both ears is a very difficult matter. So far as I know there is no reliable test. One is obliged to rely entirely upon general observation of the patient's doing.

When deafness is alleged to exist in one ear only, the test proposed by Dr. Coggens is available. This consists in plugging the ear piece corresponding to the normal ear, of a binaural stethoscope. The instrument is then put on the patient, and his power of hearing tested. If he hears through the instrument, it can only be by his alleged deaf ear.

VIII. Skin diseases have been simulated. Duhring and Fagge refer to this point in their works. Mustard oil, nitric acid, cantharides, croton oil, turpentine and other agents have been employed for the purpose of deception by their ability to produce local redness and vesication.*

IX. Tumors may be simulated. In the *Medical Record*, xxxiv., p. 307, is reported the case of a girl who applied for the treatment of a tumor of one cheek. One surgeon had pronounced it incurable; another had advised operation. Still another, making a more thorough examination found a ball of yarn which she had stuffed in her mouth to cause the trouble. No cause for the malingering was discovered.

I have in the above outlined some of the conditions which unprincipled parties may simulate for selfish purposes. If this narration shall be the means of preventing any one from being dragged into legal cases, my labor shall not have been in vain.

COCAINE IN ACUTE INFLAMMATION OF THE EAR.—Wolfenstein recommends more frequent application of cocaine than is usually made. Since adopting this plan of treatment, he has found that almost all his patients with acute otitis media recover without suppuration, while it formerly supervened in many cases. As soon as "ear-ache" is complained of, he instils five or six drops of a 5 per cent. solution of hydrochlorate of cocaine into the ear, the head being bent toward the opposite side. The pain disappears in ten or fifteen minutes, and the instillation is repeated when it returns. Sometimes, a single instillation aborts the attack, especially in those cases arising from bathing. Cases of acute otitis media generally require only two or three days, with four or five instillations daily. The pain and inflammation rapidly disappear, and the hearing is restored very quickly. In severe cases, where suppuration impends or has occurred, the solution must be used every hour or two till the pain ceases. In six cases of scarlatina otitis the remedy was applied hourly till the pain ceased, and in all suppuration was avoided. He uses a 5 per cent. solution (in very severe cases 8 to 10 per cent.) in distilled water, with a few grains of boric acid to each ounce. He has never seen the slightest toxic effect in these cases, —*New York Medical Journal*, November 5th.

* Papers on feigned diseases of the skin will be found as follows: By Mr. Startin, *British Medical Journal*, January 8, 1870; by Dr. Fagge, *British Medical Journal*, February 12th and March 26, 1870; by Tilbury Fox, *Lancet*, October 30, 1875.

EDITORIAL.

THE PROPOSED MEDICAL EXAMINING BOARDS FOR PENNSYLVANIA.

THERE are three propositions to create medical examining boards, before the Legislature of Pennsylvania, at present. One, an allopathic measure, to establish a *single* board of medical examiners to be composed of nine members to be appointed by the Governor. This is a *restrictive* measure, borrowed from European countries with *destructive* tendencies for the homœopathic and eclectic schools. Second, an eclectic measure, proposing a single board of nine members, three to be appointed from each school. The principle involved is that of *equal*, but *perpetual minority* representation. While a fairer bill than the first, it would force into coalition three antagonistic schools, robbing each of its full measure of independence. The third bill is an impartial and safe measure assuring the maintenance of the identity and integrity of each of the three schools submitted by the Homœopathic Medical Society of the State of Pennsylvania. It provides for three separate and distinct boards, of seven members each, to be appointed by the Governor, one for each school of medicine.

The allopathic members of the medical profession claim that their bill is fair. They are blinded by their desire for the *control* of medical licensure—otherwise they would be heartily dissatisfied with many of its provisions and *lack* of provisions. To test an applicant as to his ability to practice medicine and to omit the examination in therapeutics, including practice and materia medica is farcical. This omission was a dire necessity to secure majority control and has deceived no one, not even themselves.

The dangerous feature of the single board bill is cleverly masked by the provision “that the Governor shall appoint.” It has the appearance of equity and fair dealing and is calculated to quiet the opposition that would have been called forth if the plain statement had appeared, “the allopathic school being more numerous it shall have the majority representation.” The principle of establishing a single board of medical examiners of necessity means the principle of *minority* representation. They are one and inseparable, one proposition involving the other. This dual principle was recognized and the appointments were left to the discretion of the Governor. It is

an ingenious device put forward in accordance with the frequently repeated assertions, to diminish the influence, retard the progress, and in the end obliterate the homœopathic school.

The claim of the allopathic school, that because it is more numerous, it is authorized in assuming legal control of all medical affairs, regardless of the corporate rights of the homœopathic and eclectic schools is absurd. The function of an examining board is purely *administrative* and the judicial powers of one school should be no greater than the other two. The question is not that of relative numbers, but of *equal rights and privileges*.

The civic rights and privileges of the allopathic school are no greater than those of homœopathic, even if they numbered a thousand to one. It is American to grant the same privileges to all classes of citizens. All political parties, and all religious bodies have exactly the same rights, no matter what their relative numerical strength may be. And the homœopathic and eclectic medical schools are right in demanding the same and in opposing the greed for control of the allopathic school.

The old-school physicians appear willing to approve the principle of representation of the three schools in the single board, but they are not willing to submit themselves to minority control, and yet they have no more at stake than the homœopathic school—in fact not as much. Why then are they striving so hard to force their opponent schools into the position of minority representation? It is because they want the power to dictate who shall and who shall not practice medicine in the limits of the Commonwealth.

The allopathic physicians of Pennsylvania have admitted that the three board law as administered in the State of New York is working to the satisfaction of all schools and ably protects the public, and have said it would be acceptable to them if there was a supervising educational body in the State similar to the Board of Regents in New York; to this the homœopathic school gives hearty accord.

The Judiciary General Committee of the House of Representatives will no doubt readily incorporate in the three board bill, a provision, creating a body of laymen with functions similar to the New York Regents, who will be able, satisfactorily, to make the appointments to the boards, and impartially conduct the examinations. In such a case provision for previous nomination of appointees to be made by the state societies, and that the appointments shall be made by the said educational board of laymen should be provided for in the bill.

With this compromise, which will be perfectly acceptable to the homœopathic school, even if it is extended to the supervision of a required preliminary examination for medical students, or without it, the three board bill as submitted by the Homœopathic Medical Society is equitable and conservative in all its provisions and provides for every contingency.

It is an impartial law, equal in application, the representatives of each of the three schools being placed upon the same footing, no preference being shown to one more than another.

It is a thoroughly effective law, its provisions being sufficiently comprehensive, and its operations open to public inspection.

It is a safe law, in that it cannot be made instrumental in awakening sectional jealousies, being equal in its bearing upon all schools.

It is a proved law, having been in satisfactory operation in several states, notably New York, Delaware, Maryland, Florida and California.

Being absolutely equal in bearing upon all schools, thoroughly effective in its provisions, safe in its application, and satisfactorily administered in other States—meeting all the requirements of the single board bill, and withal just and equitable to both the laity and the profession, the members of the Legislature will no doubt give it their earnest consideration, and render to the State that service in justice and equity which its citizens have a right to expect, and have confidence they will receive at their hands.

THE TREATMENT OF EXOPHTHALMIC GOITRE.

THE peculiar character of the symptoms presented by exophthalmic goitre, otherwise known as Basedow's disease and Graves's disease, has always made it a subject of great interest to the clinician, an interest that has been made only greater by the mystery attached to the pathology of the affection. Ideas as to treatment have been rampant, each authority advocating a plan of procedure based upon his own peculiar notions concerning the origin of the affection. The natural result of these widely conflicting therapeutic measures has created an unhealthy skepticism concerning the treatment of exophthalmic goitre. This is reflected in our text-books on practice, on reference to which the reader learns that he can do but little or nothing but treat the patient on expectant principles, permitting

nature to be as kind to him and his patient as she is pleased to be. More than this he must not expect.

A thorough study of the general literature of the subject and clinical experience show that amidst all this confusion there is some order. There are measures upon which we can rely, and by the aid of which we can, in many cases, cure the disease, and in the majority of the remainder so mitigate its course as to give the patient a comparatively comfortable existence. It is true that our ideal, a rapid cure, is unattainable. Success can only be gained by attention to details and perseverance for many months. Nothing whatever is to be gained by therapeutic fickleness or light flirtation with this or that medicinal agent.

One's ideas concerning the pathology of the disease naturally govern him in his management of it. So it is with exophthalmic goitre. As we have said before, authorities differ. Gradually it is being recognized that the three prominent symptoms of the disease which have given it its name do not constitute the whole affection, and that the true condition present is that of a neurosis.

Probably the most important element in the treatment of exophthalmic goitre is rest. How nearly complete this should be in individual cases, the judgment of the physician only can decide. When the temperament of the patient will permit of it, absolute rest in bed for many weeks will prove best. When, however, the enforced idleness causes the patient's mind to dwell altogether too much on the ailment, modifications of the rest treatment are necessary. In no case is it safe for the patient to disregard the illness, and go about his or her duties as in health. It is really remarkable to note the wonderful influence absolute rest will exert upon the pulse-rate, and the general symptoms giving rise to discomfort.

The diet of these patients should be nutritious. Eggs, milk, meat and other nourishing articles of food should be relied on. Schnaubert (*London Medical Record*, February 15, 1883) recommends an exclusive diet of skimmed-milk, and reports cases treated successfully by this measure. The chronicity of the disease must make this measure irksome to the patient. It seems to us that but little can be gained from it, and that a generous, easily digestible diet is the best adapted to the needs of the patients. Individual cases may, of course, thrive better following Schnaubert's plan.

Moral treatment is all-important, as indeed it is in all neurotic affections. Emotional influences must be removed as much as pos-

sible. Sight must not be lost of the fact that the disease may originate in fright, grief, or other agencies exerting a depressing influence on the mind. Many times it may prove advisable to send the patient away from home, always, however, to a quiet place. As to the character of the resort selected, authorities differ. Gowers favors the seaside; Nothnagel advises the selection of a place at a high altitude; Curtin condemns mountain resorts in unqualified terms; Dana takes a middle ground.

An observation of Dr. Louise Fiske Bryson, to the effect that patients with exophthalmic goitre exhibit decidedly deficient power of chest expansion, has led Dana to recommend breathing exercises as a therapeutic adjuvant, and, he claims, with quite considerable success.

Hydrotherapy finds a place of some importance in the therapeutics of this disease. Dana advises systematic treatment with tepid half-baths and the spinal ice-bag. Nothnagel and others strongly urge the application of cold over the region of the heart as the most efficient agent against the dyspnoea, which occasionally becomes a prominent source of suffering. Gowers advises for the same symptom "derivatives," as "hip-baths and mustard-plasters to the feet, with cold to the thyroid (if its enlargement is sufficient to be a cause of dyspnoea)." Hingston Fox recommends the application of Leiter's coil to the thyroid.

Corning (*New York Medical Journal*, September 13, 1890), bases his treatment entirely on his understanding of the circulatory disturbances present in these cases. To prevent excessive blood-pressure in the thyroid, cranial cavity and orbit, he places the patient in a warm bath at least once a day and causes her to remain there three-quarters of an hour or more. When the derivative action of the bath is complete, he orders straps to be fastened about the leg, either above or below the knee, according to the amount of derivation which seems necessary in each case. The band is made just sufficiently tight to interfere with the venous return without obstructing the arterial flow. During the immersion the eyes are bandaged, but the author is not at all sure that any permanent advantage is gained by this procedure. He likewise advises at the same time the application of styptic collodion to the enlarged thyroid. This, he is certain, does great good.

The general impression concerning the influence of pregnancy on patients with exophthalmic goitre is that the latter disease is favorably influenced thereby. Some French physicians have even advised preg-

nancy as a means of treatment. Hutchinson says that the disease never occurs during pregnancy. Haberslin (*British Medical Journal*, 1890, vol. ii., p. 96), however, reports a case in which pregnancy actually excited the disease.

The removal of nasal hypertrophies has acted curatively in a few cases. Hack (*Manchester Medical Chronicle*, August, 1886), reports a case of exophthalmic goitre in a mouth-breather. He cauterized the mucous membrane of one nasal cavity. On the following day the exophthalmos on the corresponding side had diminished greatly. The operation was then repeated on the opposite side with equally favorable result. The case was thus cured. Masehold (*University Medical Magazine*, vol. iv., p. 604), has cured one case by the treatment of nasal hypertrophy.

The surgeons find in exophthalmic goitre a prospective, though, to our mind, a highly problematical field. The general character of the operative procedures proposed is, as a rule, so dangerous, that they should only be adopted as a last resort. In cases in which dyspnoea is uncontrollable, division of the isthmus of the thyroid has been recommended by Hingston Fox (*Lancet*, 1891, vol. ii., p. 886). Dressman has resorted to more radical procedures, and has reported three cases of cure following ligature of the thyroid arteries (*University Medical Magazine*, vol. iv., p. 605). Lembke goes still farther and recommends removal of one-half of the thyroid gland. He reports two cases thus cured. So enthusiastic is he in his endorsement of this radical surgical procedure that he practically advises surgical to the exclusion of medical treatment (*New York Medical Journal*, vol. liii., p. 727). It is urged that the operation be resorted to early in the course of the disease, to our mind a very illogical recommendation, in view of the danger incurred and the results obtained by good hygienic and medical treatment. In Lembke's operations, tracheotomy was performed preliminary to the thyroidectomy.

Electrical treatment has been strongly urged as invaluable in the management of exophthalmic goitre. Those who have used it praise it highly, and look with surprise at those who cast doubts on its possibilities. Methods vary, however, with different authors.

Leslie Phillips (*British Medical Journal*, 1885, vol. ii., p. 964), reports a cure by subaural galvanization, a current of seven milliamperes being passed for ten minutes daily.

Suckling (*British Medical Journal*, 1885, vol. ii., p. 1060), considers galvanization of the cervical sympathetic the most efficient means of treatment, as he has greatly benefited several cases by it.

He makes no claim to cure; in fact, he says the disease is incurable.

Corning (*New York Medical Journal*, September 13, 1890), submits the tumor to daily galvanic applications. He uses an electrode of potter's clay moistened with iodine, connected with the positive pole of the battery. The negative, consisting of a large, flat electrode, is placed at the back of the neck. These applications should be from ten to twenty-five minutes each. Following this method considerable iodine must be introduced into the goitre, so that should cure or improvement follow, it is not easy to learn its cause.

Vigoureux (*HAHNEMANNIAN MONTHLY*, April, 1888), believes in faradism and lays down the following explicit directions:

(1) A large electrode from 7 to 8 c.c. in diameter is applied to the inferior part of the neck posteriorly, and is held in position by means of a band. The other electrode is olive-shaped or button-shaped, less than 1 c.c. ($\frac{2}{3}$ inch) in diameter, and is connected with the negative pole of the battery. This electrode is applied behind the angle of the jaw, in front of the sterno-mastoid muscle, and is made to press upon the carotid artery. The application is made during a minute and a half, and is then transferred to the opposite side, where it is continued for the same length of time. (2) The small electrode is then passed lightly over both orbiculares palpebrarum in turn. (3) The olive electrode is now replaced by a plate 4 c.c. ($1\frac{3}{8}$ inch) in diameter, and is applied to the thyroid tumor. (4) The small electrode is now rendered positive, and is applied to the præcordial region, in the third intercostal space to the left of the sternum, and the current should be sufficiently strong just to excite fibrillary contractions. The application is made for two or three minutes. The séances are repeated every second day.

Rockwell (*Medical Record*, vol. xviii., p. 286), obtains "good results by placing the cathode over the cilio-spinal centre above the seventh cervical vertebra, and the anode in the auriculo-maxillary fossa, gradually drawing the latter (after a few moments of stable treatment) along the inner border of the sterno-cleido muscle to its lower extremity. The second step in this process consists in removing the anode to the position occupied by the cathode and placing the latter over the solar plexus, using for a minute or so longer a greatly increased strength of current. In one case, failing after considerable effort to accomplish more than a very moderate degree of amelioration, I made use of currents that were rapidly increased and diminished every few seconds with very great benefit.

Cardew (*Lancet*, 1892, vol. i., pp. 6 and 64) describes a treatment the details of which he leaves to the patient's attendants. He gives his principles in a few words as follows: 1. Galvanism is superior to faradism. 2. Very weak current strength (two to three milliamperes) is sufficient. 3. Each application should last six minutes. Frequent applications (three times a day) should be made. 4. The anode should be placed on the nape of the neck, the centre of its lower border corresponding to the seventh cervical spinous process, and be held firmly in that position during the application. The cathode should be moved up and down the side of the neck from the mastoid process along the course of the great nerves. The cases reported by Cardew show conclusively the value of his method, which it will be noticed is but a portion of Rockwell's procedure, simplified for lay administration of the current.

The great objection to the use of electricity in the treatment of exophthalmic goitre lies in the necessity for frequent administration. If the applications are to be made by the physician, frequent calls at his office are necessary, and this is a big item of expense which few can afford. On the other hand, if left to the patient, details are not properly carried out. As to its value in reducing the pulse rate, all are agreed.

Opinions of great variety exist among allopathic authorities as to the best drug treatment. In former years, cardiac tonics represented by digitalis held full sway, and received unqualified praise. Now digitalis is condemned or ignored as useless by Delafield, Peabody, Nothnagel, and Janeway. The objection to the drug is found in the fact that it contracts the smaller bloodvessels, thus increasing vascular tension. Such an effect is undesirable in this disease. Notwithstanding this latter observation, Johnston, of Washington, resorts to ergot for its contractile effects on the bloodvessels, and believes he obtains good results (*Journal of the American Medical Association*, vol. xiii., p. 825).

Strophanthus is one of the latest candidates for favor, and seems to have been used with good results. Its action upon the heart without affecting the bloodvessels forms the ground for its administration.

Cannabin has been strongly urged by Valiere (*Medical News*, September 21, 1889).

Quite a number of cures have been reported from homœopathic medication. Among the remedies that stand foremost in the therapy of exophthalmic goitre are aurum, lycopus, belladonna, ferrum, spongia, badiaga, and many others.

Wildebrandt (*Hom. Klinik*, 1869, p. 118) reports a cure with *secale*.

Hofrichter reports two cures of cases with eccentric dilatation of the heart by *natrum mur.* 24 (*U. S. Med. and Surg. Journal*, vol. iv., p. 256).

Dr. H. Wheeler (*British Journal of Homœopathy*, vol. xxxiii., p. 688) reports three cases treated by *ferrum* in substantial doses with *cactus 1x*. One case was cured and the others substantially relieved. In the discussion following this paper Dr. Hughes reported cures by *belladonna* first decimal, and *natrum mur.*, 12 and 30. Dr. Kitching said he had seen but one case, and that occurred during pregnancy. It was greatly relieved by *belladonna 1x* three times a day. She later developed albuminuria and was prematurely confined, after which all symptoms disappeared. Dr. Yeldham spoke in praise of *ferrum* and *belladonna*, giving a case of his own that had yielded to these remedies. Dr. Bayes said that his recent experience with the disease had been favorable, he having used remedies as indicated, principally, however, *spongia*, *spigelia*, *arnica*, *silicea*, *conium*, or *iodine*, and occasionally *digitalis*. Dr. Dudgeon reported a case which recovered under the successive administration of *digitalis*, *fer. mur.*, and *arsenic*.

Belladonna has indeed proven a valuable remedy. In addition to the endorsement given above, Hughes praises it in his *Manual of Therapeutics* (second edition, p. 223), and adds that Kidd reported a good result from it years ago, and that Jousset looks upon it as one of the foremost remedies. Hughes likewise directs attention to the homœopathicity of *nitrite of amyl* and *glonoin*.

Of all remedies, *lycopus* is probably the most efficient. It was first introduced by Hale in his valuable work on new remedies, and its homœopathicity to the disease under consideration satisfactorily demonstrated. Lilienthal (*North American Journal of Homœopathy*, February, 1877, p. 380) speaks in unqualified praise of it, and quotes Sana and others in still further support of the drug. We might say, in passing, that the above-quoted article by Lilienthal is probably the best exposition of the therapeutics of the disease to be found anywhere.

Aurum mur., given by Kafka (*HAHNEMANNIAN MONTHLY*, 1890, p. 859) because of the marked nervous depression, effected a cure. The patient had great palpitation at the slightest noise; tendency to cry; fear of death, alternating with nervous erethism and excessive cardiac palpitation. The symptomatology of *aurum* should make it a remedy frequently called for in exophthalmic goitre.

St. Clair Smith greatly relieved a case by sambucus (*North American Journal of Homœopathy*, 1889, p. 258), though a cure was not effected. The drug was prescribed purely on symptomatic indications.

Zwingenberg (*British Journal of Homœopathy*, vol. xxxiii., p. 547) has obtained cures from the administration of guaiacum 1.

Sulphur will frequently be called for by the symptoms.

One might go to much greater length in the consideration of the treatment of this disease with advantage to the reader. The above outline of the therapeutics of exophthalmic goitre will afford, we trust, a foundation on which successful treatment may be obtained.

THE HAHNEMANN MONUMENT MOVEMENT.

AT the recent meeting of the American Institute of Homœopathy held at the city of Washington, it was resolved, "That a national monument be erected to the memory of Samuel Hahnemann in the city of Washington, and that a committee be appointed to solicit subscriptions and take charge of the project." The resolution was unanimously adopted and a committee was appointed with Dr. J. H. McClelland, of Pittsburgh, Pa., as chairman. The committee immediately commenced work and formulated plans to raise a monument befitting the memory of a great medical discoverer, whose learning and genius brought about the greatest reformation in the history of medical science, by the discovery of a rational theory of drug action. The plans look to the erection of a heroic statue in bronze upon a granite pedestal; a work of art requiring a fund of from \$50,000 to \$100,000. A most eligible site has already been promised in one of the public squares at the national capital. At the meeting in Washington \$1000 was raised at once, and since then funds have been started in a number of cities and are rapidly growing. Pittsburgh has raised nearly \$1000, and the Philadelphia committee, with Dr. C. S. Schwenk, as chairman, is determined to more than double this amount, while the State organization under Dr. Korndœrfer will roll up a large amount doing credit both to the monument movement and the State. Every homœopathic physician should deem it a privilege to subscribe liberally and also to invite their patrons to join with them in honoring the memory of Samuel Hahnemann.

GLEANINGS.

GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D., AND FRANK H. PRITCHARD, M.D.

METASTASIS OF PSORIASIS.—Dr. Gaucher calls attention to the fact that psoriatic patients are subject to multiple diathetic manifestations, especially of the respiratory apparatus, the digestive tract, etc. Nowadays these are generally regarded as coincidents, yet the writer is not of this opinion, and looks upon them as manifestations of the same diathesis. It is quite certain that these symptoms, at first cutaneous and then visceral phenomena are the result of the same cause in general; an auto-intoxication in connection with a disturbance of nutrition. The evolution of these symptoms pursues a grave course, the cutaneous lesions being followed by the visceral and vascular lesions later. Thus the ancient doctrine of metastases comes back for our belief. He cites the following three cases in support of his view:

The first was a case of very grave acute articular rheumatism, with endocarditis and cerebral complications, which developing after, immediately a cure of an inveterate psoriasis.

In a second case the psoriasis was succeeded by progressive dyspepsia and an ulcerative carditis of such a gravity as to lead one to think of cancer of the stomach. Finally, an attack of asthma finished the picture. All these symptoms disappeared after the reappearance of the eruption.

In the third case the chronic gastro-intestinal symptoms followed a spontaneous disappearance of eruption.

In all these cases there was a metastasis, *i. e.*, a displacement of the morbid poison from the skin to the internal organs. Therefore, one should exercise care in the treatment of psoriasis with local means, and not confine the treatment to local measures alone, at the same time watching the general health of the patient.—*La Semaine Médicale*, No. 50, 1892.

ACUTE PARENCHYMATOUS DEGENERATION OF THE LIVER.—Prof. Liebermeister, of Tuebingen, Germany, includes under this term that state where the hepatic cells undergo destructive alterations. It is accompanied by great amount of icterus and especially severe disturbance of the central nervous system. In the beginning the liver is enlarged, afterwards diminished, in size; then we have that disease known as acute yellow atrophy. This term is not proper, as it only designates a stage of the affection, and the case may not have progressed as far as atrophy before a fatal termination. If the case last longer than nine days, a decrease in size may be expected. The stools are rarely entirely colorless until the end. The spleen is usually enlarged, sometimes to double its volume. The kidneys are also involved, yet to a less extent than the liver. Slight albuminuria is now and then present. The heart undergoes fatty degeneration. Hæmorrhages take place, not only into the various organs, but also into the pleura, the pericardium, the external skin, and the mucous membranes, as well as into the organs of the portal system. These are rarely vast hæmorrhages, but rather slight effusions. Intense icterus is always present, extending over the entire body, yet it does not attain the degree that is observed from biliary obstruction. The disease may be primary or secondary.

Acute yellow atrophy may be taken as an example of the primary affection. It is a rare disease, and appears sporadically. A large number of cases have been observed in pregnant and parturient women, yet they cannot be said to be predisposed. Excessive use of alcohol, and any cause producing a fatty liver, will predispose. A specific infection is often supposed to be present. Yellow fever is constantly accompanied by this affection; indeed, sporadic cases of this disease have been diagnosticated as sporadic cases of yellow fever.

Epidemic icterus has been observed, though the disease is always limited in its extent and but slightly dangerous. It resembles yellow fever in some respects.

The writer regards it as a parallel form of yellow fever, and related to it, as cholera morbus is to Asiatic cholera, varicella to the small-pox, or roetheln to measles or scarlet fever. Fatal cases revealed, anatomically, a condition similar to that of yellow fever.

Poisoning by some substances—for instance, phosphorus—produces acute parenchymatous degeneration of the liver. The resemblance is so striking that the most experienced is unable to detect a difference. In poisoning by phosphorus atrophy rarely sets in, for the patients rarely survive the seventh day. Alcohol, chloroform, arsenic, mineral acids, and other poisons may produce it yet less frequently (lead and antimony also—EDS.). Secondarily, it may follow other hepatic affections; especially where the biliary stasis is of long duration. Also in the portal form of cirrhosis, in fatty liver, in hepatic abscess, and miliary tuberculosis, it may suddenly, and without apparent cause, set in.

It may appear in long-lasting febrile affections as typhoid fever, recurrent fever, or puerperal fever, and finally complicate the case.

First, there appears a stage of gastric disturbance, with more or less fever, then follows a period of more or less remission or intermission, during which the fever and other symptoms decrease in intensity. In this interval icterus sets in, and the second stage has begun, with its grave choleraic symptoms, nervous disturbances, hæmorrhagic diathesis, general prostration, and cardiac paralysis. The prognosis is very unfavorable.—*Deutsche Medicinische Wochenschrift*, No. 48, 1892.

PRIMARY ENLARGEMENT OF THE SPLEEN AND SPLENIC LEUCOCYTHÆMIA.—Prof. Peter, of Paris, had two patients under observation; one, with an enlargement of the spleen who, on walking rapidly would feel a sensation of great weight in the left side. On examination the spleen was found enlarged to a great size. Subcutaneous injections of the arsenite of potash reduced it. The blood of this patient was nearly normal, no enlarged lymphatic glands. The second patient had been liable to colds for several years, which state was succeeded by digestive troubles, with disgust for food, especially meat, vomiting and swelling of the abdomen. The skin was slightly icteric, face emaciated to a slight extent, sclerotics and lips colorless, tonsils somewhat enlarged. The lymphatics were enlarged, the abdomen augmented in size, especially on the left side. The left hypochondrium was occupied by a tumor, extending from the ribs to the iliac crest and nearly to the pubis, with a greatest diameter of 35 centimetres. Toward the right the dulness on percussion blended into that of the liver. The liver also was hypertrophic. His tongue was white; complete anorexia, especially for meat. Fowler's solution was given hypodermically; the condition of the patient improved until his spleen had greatly decreased in volume and the number of blood-corpuscles risen to nearly the normal. Finally, he was seized with a pleurisy which carried him off. This is a very mysterious affection. In the first case the spleen alone was affected and the blood normal, in the second both blood and spleen were involved. The beginning of the affection may be insidious; there may be merely a sensation of weight in the left hypochondrium, while little by little, a globular anæmia sets in, or there are general symptoms of asthenia or anæmia. The spleen enlarges. The characteristics of primary megalosplenism are: hypertrophy of the spleen and anæmia. The number of white corpuscles is not increased. The red corpuscles are diminished in number, shape and size. At the necropsy the spleen is found hypertrophied, surrounded by a thickened and adherent capsule. The connective tissue of the spleen is increased, the glomerules of Malpighi atrophic and the adenoid tissue disappears as a fibrous hypertrophy of the spleen, a sort of cirrhosis. The appearance of leucocytosis may be but a question of time; it will certainly set in.

A condition entitled aleukæmic lymphadenia has been described. Struempell calls it splenic anæmia, but it may transform itself later into leukæmic lymphadenia. In cases of primary enlargement of the spleen he thinks where the blood has not undergone changes that splenectomy may be of service.—*Le Bulletin Medical*, No 2, 1893.

DIAGNOSTIC SIGNIFICANCE OF VENOUS AND ARTERIAL MURMURS IN THE NECK.—Dr. James K. Crook, in reviewing this subject, calls attention to the fact that these murmurs have been familiar to the profession since the days of Laennec, more than seventy years ago. Generally, they have been attributed to the pathological changes in the blood constituting the condition known as anæmia. Their exact diagnostic relations have never reached any fixed or settled value. He quotes the opinions of a dozen noted writers, showing that their combined testimony is very confus-

ing, and, in some instances, absolutely contradictory. For instance, Fagge states: "It is important to notice that none of these murmurs (arterial and venous) are of the slightest significance from a clinical point of view, so far as the diagnosis of anæmia itself is concerned." Vierordt: "Strictly speaking, no diagnostic importance is to be attached to these phenomena." Flint: "Of special significance in the diagnosis of anæmia is the presence of these murmurs." Immerman: "The *bruit de diable* is of special importance in the diagnosis of anæmia." In view of this unsatisfactory evidence, the writer has examined fifteen hundred persons of various ages and conditions, and has endeavored to show what relations these phenomena (neck murmurs) bear to diseased conditions, and what value to place upon them as a means of diagnosis. All accidental murmurs incidental to improper pressure of stethoscope, or twisting of neck unduly, and those cases of inspiratory breathing-sounds which in some persons so nearly simulate the *bruit de diable*, were rigidly excluded. In the fifteen hundred cases examined, he discovered fifty-one cases of well-marked and unmistakable anæmic bruits or murmurs, originating in the blood-vessels, which equaled 3.4 per cent. of the whole number. Of the fifty-one cases, forty-three were females, in a total of six hundred and eighteen females examined, or 6.95 per cent. There were eight males out of a total of eight hundred and eighty-two males examined, a little less than 1 per cent. It was shown that the murmurs occurred usually during early adult life. Of 31 well-marked cases of anæmia or chlorosis, 28, or more than 90 per cent., presented hæmic bruits. The next disease in order of frequency of vascular sound, was phthisis (in which affection anæmia plays an important part); of 122 cases, 8 presented murmurs. Among the remaining 1349 persons examined, there were only 15 in whom a true hæmic bruit was elicited. The author's conclusions are as follows: 1. Hæmic bruits are rarely heard in healthy persons. 2. They are not often heard in persons not showing a considerable degree of anæmia. 3. They are heard in 90 per cent. of persons showing a well-marked degree of anæmia. 4. They are, therefore, of great significance in the diagnosis of this condition.—*Amer. Jour. Med. Science*, February, 1893.

CONJUNCTIVITIS AND INFECTIOUS PNEUMONIA.—M. Rendee was consulted by a patient of good general health with regard to a conjunctivitis of the left eye, with marked serous chemosis. There was no fever. On the following day the ocular trouble was somewhat aggravated, and in addition there was a patch of erysipelas in the neighborhood of the eye. There was no elevation of temperature and no general symptoms and nothing in nose or pharynx to account for the erysipelas. The erysipelas disappeared completely within forty-eight hours. On the night of the third day the general condition suddenly, and without known cause, became grave. A double pneumonia of the most infectious character speedily developed, and carried off the patient in three days. There was no cough, expectoration or dyspnoea, though the physical signs were well marked on both sides. There was complete anuria for two days before death.—*Glasgow Medical Journal*, February, 1893.

ACUTE TUBERCULOUS PERICARDITIS.—Prof. Jaccoud, of Paris, had a young woman under observation, with grave anæmia. Her condition was greatly ameliorated by treatment and, one day, while walking in the garden she was seized with a chill, fever, lassitude and high pulse. Lungs and pleura found normal. Pericarditic friction sounds at the apex of the heart. These increased in extent and strength until they were audible even posteriorly. The same sounds appeared in the right pleura, but the temperature fell a few days after the severe chill. Three weeks after there was complete apyrexia continuing for several weeks. The friction sounds continued at the cardiac apex; endocardiac; no souffle. They gradually disappeared and complete adhesion of the pericardium to the heart took place with consequent exhaustion of the heart muscle, asystolia and death. Besides cold and rheumatism three other states are to be thought of in acute pericarditis—in tuberculosis, cancer and sarcoma.

Tuberculous pericarditis of sudden origin often is due to extension of tuberculosis of the lungs, pleura, or lymphatic glands. In order to diagnosticate it certainly a source of tuberculous infection must be discovered, lungs, pleura, etc. Sometimes, though rarely, it is primary.

Carcinomatous pericarditis is always secondary.

Sarcoma also invades secondarily; a small sarcoma will be found in another part, for example in severe cases on the iliac crest. This woman succumbed with the symptoms of systolia—permanent œdema, then anasarca, albuminuria, constant

dyspnoea. The liver was enlarged, even beyond that of those with mitral stenosis. The bases of the lungs congested. No cardiac remedy appeared to have an influence. Delirium set in (encephalic blood-stasis) and death three and a half months after the pericardiac adhesions formed. An individual with cardiac symphysis, adhesions of the pericardium to the heart, is in the same precarious condition as one suffering from an organic valvular lesion. The necropsy showed this case to be due to extension of the disease from the mediastinal glands. They may be latently affected for years without extension. Acute tuberculous pericarditis is rare; it terminates in cardiac symphysis and death from asystolia. Young people under thirty are relatively frequently attacked. An effusion rarely occurs.—*La Semaine Medicale*, No. 3, 1893.

GANGRENE OF THE HAND FOLLOWING THE GRIPPE.—Dr. Roland publishes the case of a robust blacksmith, æt. 31, who was severely attacked by the influenza. When hardly over his disease he resumed his occupation and performed very fatiguing work with his right hand. He was seized with very violent pain in this member which was regarded as of rheumatic origin. But the hand became white, livid, the pulsations of the radial, and even of the brachial artery, at the bend of the elbow, ceased. Finally, the fingers and the lower portion of the hand took on the characteristic black color of arterial gangrene, often observed in the lower but rarely seen in gangrene of the upper extremity. Demarcation was apparent and he was about to recover when his general condition aggravated, the right foot was implicated and death followed. Cases of gangrene following influenza have been recorded, but gangrene, of arterial origin, generally due to an arterial embolus has not been observed in the hand.—*Le Bulletin Medical*, No. 2, 1893.

[Dr. Laache, of Christiana, Norway, has recently written a very interesting article on "Peripheral Thrombosis in Various Affections." It is an expanded paper that he read before the Society of Scandinavian Naturalists, in Copenhagen, July, 1892. He observed seven cases where thrombosis, generally of venous origin, followed influenza. The older literature on the grippe does not mention phlebitis or thrombosis as a complication. Rendu and Buoquoy have each observed a case, in light attacks of the disease where the affection in its intensity was in astonishing contrast to the mildness of the original disease. It is a rare complication; in the Danish records only five are recorded, in the Swedish publications six, while in the large and comprehensive German official work, appearing under Leyden's and Guttman's supervision, only twenty-five cases are returned from entire Germany.—*Norsk Magazin for Læbevidenskaben*, No. 9, 1892.

Dr. A. Ripperger, of Munich, in his work, *Die Influenza*, etc., 1892, gives the complications of the circulatory system but short consideration. After pericarditis in pregnancy he places endocarditis and then phlebitis. Laverus claims phlebitis to be a frequent complication. In Saxony thrombosis of the veins was observed four times, once in the femoral. In Mayence, a case of thrombosis of the femoral and one of the splenic artery are recorded.—EDS.]

HYDROTHERAPY IN NERVOUS DISEASES.—Dr. Fred. Peterson contributes a most interesting article on this subject, and lays down the following general laws:

1. Cold and warm baths affect the central nervous system in a reflex manner by stimulating the sensory nerves of the skin and the vascular nerves, and thus influencing the cerebral circulation. Cold excites and warmth diminishes irritability when thus applied.
2. Short cold baths, especially when combined with sprinkling, showering, or rubbing are powerfully stimulating, exhilarating and tonic.
3. Prolonged warm baths, steam and hot-air baths, and the hot pack are relaxing, fatiguing and soporific.
4. A cold bath stimulates various reflexes in the body, such as peristalsis and the visceral reflexes in the sacral portion of the spinal cord.
5. Warm baths by soothing peripheral nerve irritability exert calmative influence over the central nervous system. They mitigate reflex spasm and contractions in voluntary or involuntary muscles.
6. Cold applications to the skin stimulate vaso-dilator nerves, dilate peripheral vessels and increase blood pressure. Warm applications also dilate superficial capillaries, but by diminishing the tone of the vessel walls, they also reduce arterial tension.
7. To lower the irritability of individual nerves or of the entire nervous system, prolonged warm baths or the hot pack are indicated.

8. As many hydro-therapeutic measures tend to reduce temperature, it is important to remember that in non-febrile cases, in anæmic conditions, and in debilitated states, the temperature must be raised artificially before subjecting patients to hydropathic treatment. In some cases the temperature of the body on rising from bed in the morning is sufficient; in others a short stay in the hot-box is needed.

For Tonic and Refreshing Effects.—A cold rain-bath (50° to 70°) the patient rubbing himself while in the bath. Duration, five to ten seconds; or the half-bath in a tub at 65° to 75° F., ten to thirty minutes. By half-bath is meant only six to eight inches of water in the tub, in which the patient lies and splashes about and is rubbed by an attendant. The object in both is to get the exhilarating and stimulating effect of the water impinging upon the skin. Such a bath should be taken every morning.

For Powerful Revulsive and Derivative Effects.—The cold douche increases reflex excitability, and causes hyperæsthesia of the skin. It is a powerful stimulus, mental and physical. By means of various nozzles it may be ejected in the form of a jet, a spray, a shower, a fan, and Scotch douche. Such procedures are indicated in lethargic and hysterical forms of insanity, where there is sluggishness of the intellect, apathy, stupor, catalepsy, etc., and in melancholic cases, and in all cases where there is anæmia, chlorosis or gastric disorders.

To Produce Sleep.—The prolonged warm whole bath is indicated. Temperature 70° to 90°. Duration, one half to two hours. When of long duration the patient may be suspended in a hammock made of a sheet. Indicated in cases of melancholia with excitement and in some maniacal conditions. As a general hypnotic agent, however, applicable to all forms of insomnia among the insane, the hot wet pack stands foremost. It is applied in this way: A blanket 9 by 9 feet is spread upon the patient's bed, and upon this a sheet wrung out dry after dipping in hot water is laid. The patient lies down upon this, and the sheet is at once evenly arranged about and pressed around the whole body with the exception of the head, after which the blanket is also immediately likewise closely adjusted to every part of the patient's body. The patient remains in this for an hour or longer. All night if asleep.

Maniacal Excitement.—In this condition the measures to be carried out are those indicated for insomnia. It is not often that patients laboring under great excitement can be placed in the warm bath, but the wet pack is applicable in nearly every case. It not only diminishes the erethism, but often brings about refreshing sleep, and always when kept applied, prevents metabolic waste by motor excitement.

Congestive Headache.—These may be treated by a prolonged foot-bath, accompanied by rubbing and chafing of the feet for the mechanical effects of the water; or a strong fan douche of cold water applied to the feet very soon dilates the vessels and warms and reddens the feet. Actual experiment has shown that the temperature in the auditory meatus is lowered as much as one degree by a cold foot-bath, and the conjunctival vessels have been observed to contract.

Constipation.—In the atonic condition of the intestines in most cases of melancholia and in some other forms of insanity, a powerful stimulus to peristalsis will be found in pouring water over the abdomen when the patient is in a tonic half-bath of low temperature.

In closing the author gives some of the special indications in various nervous disorders as follows: *Anæsthesia* (cutaneous). Short cold jet and fan douches of strong pressure to the anæsthetic areas. Temperature, 50° to 70°. Duration one minute. Daily.

Angio-paralytic Hyperidrosis of the Feet.—Prolonged cold foot-bath with chafing, or fan douche of cold water to the feet. Temperature 60°. Duration, twenty minutes for bath, five minutes for douche.

Chorea.—Cold plunge beginning at 90°, daily reducing until 70° is reached.

If anæmic, spinal spray, fan douche or jet, at first warm until patient becomes accustomed to them, then gradually reduced to 60° or 50°.

Epilepsy.—Cold shower-baths and cold sponge-baths daily are beneficial. The shower-baths should be rain-like in character—that is not too forcible. In many cases a morning and evening bath (half-bath) proves very serviceable. When there is evidence of hyperæmia and increased blood-pressure in the head, the cold cap is useful. While these are the general indications for hydro-therapy, certain measures are often of use at the time of the seizures. During a fit of *status epilepticus*, it will be observed that there is one of two conditions present; either the face is pale and there are signs of brain anæmia, and in this case warm wet compresses should be

applied to the head and genitals, accompanied by friction of the trunk upwards, the body being placed with head low and arms uplifted; or there is turgescence of the vessels in the head, the face is red, the carotids beat strongly, and under such conditions a contrary procedure is indicated—cold compresses to the head, neck and genitals, strong wet beating of the feet with a high position of the head. Daily applications for thirty seconds.

Headaches, Neuralgias, and Migraines.—If anæmic, heating cephalic compresses (wring out thin linen bandages in very cold water; wrap head in capelline manner, and cover with one or two layers of dry linen or flannel). Apply at bedtime. Upon removal, envelop head in dry cloth and rub it dry.

If hyperæmic, leg bandages (a piece of towelling a yard long is dipped in cold water at one end,—one-third,—thoroughly wrung out, and wrapped closely about each leg, so that the wet surface is next the skin and the dry portion envelops the wet two or three times. Or, wet stockings may be put on and covered with dry towels). These are applied at bedtime and retained through the night.

Hysteria.—For erethytic type: Wet pack, 60° to 70°, for one hour or more, followed by massage (Putnam Jacobi); or the rain bath at 75° to 65° for thirty-five seconds daily at twenty pounds pressure (Baruch). For depressed type: Cold affusions while standing in warm water, or hot-air bath, followed by rain bath for thirty seconds at 85°, daily reducing until 65° is reached, this to be followed by spray douche for five seconds at 65°, or jet douche for three seconds at 65° to 55°. Reduce douche gradually to 50° or less, increasing pressure from two pounds to thirty (Baruch).

Hyperæsthesia (cutaneous).—Long-continued cold douches to affected area. Daily, twenty minutes, at 70° to 80°.

Insomnia.—Wet pack.

Impotence.—Brief cold sitz-baths. Daily, 56° to 64°, one to five minutes. The psychrophore, i.e., application to prostate of cold by a rubber condom or bladder secured over a rectal irrigator *au double courant*.

Incontinence of Urine.—In paresis of sphincter or detrusor, brief cold sitz-baths, daily, 56° to 64°, one to five minutes. Cold rain baths (50° to 60°) and douches as general tonics. In spasmus detrusorum vesicæ, on the contrary, prolonged lukewarm sitz-baths, daily, thirty to sixty minutes, 70° to 90°.

Locomotor-ataxia.—Prolonged warm baths, five to twenty minutes, 86° to 95°. Hot-air baths to lower extremities, followed by affusions or douches, 60° to 70°.

Neuralgia of all Types.—Hot-air bath to perspiration, every other day, followed by gradually-lowered douches.

Sciatica.—Hot-air bath until patient perspires, followed by cold plunge or douche, gradually lowered to 65°.

Spinal Cord Affections.—In various chronic diseases of the spinal cord, the daily half-bath, 65° to 82°, six to ten minutes' duration, with affusion and chafing, will be found useful. In some cases of compression and injury to the cord, in myelitis and the like, where there is paralysis of the rectum and bladder, and formation of bedsores or trophic lesions, resort may be had with advantage to the permanent bath. A sheet fastened in a bathtub makes a hammock, in which the patient lies at first for an hour or so daily; later, all the time, except at night, when he is put to bed. The water is kept at a temperature agreeable to the patient (88°).

Spinal Irritation.—"Douche filiforme" as a rubefacient and epispastic along the spinal column; or rain baths, 65° to 85°, and douches.

Spermatorrhœa.—Cold sitz-baths, five to twenty minutes, 50° to 70°, daily, at bedtime; contra-indicated in sexual irritability and active pollutions, where prolonged warm or hot sitz baths, at 90° to 98° should be used.—*American Journal of Medical Sciences*, Feb., 1893.

RIGHT-SIDED INFECTIOUS ENDOCARDITIS, OF PYÆMIC ORIGIN, FROM OTITIS MEDIA.—Prof. Huchard communicated to the Paris Hospital Society the case of a young woman, æt. 21, who presented a right-sided infectious endocarditis, after a purulent inflammation of the middle ear. The necropsy demonstrated the usual course of the disease; otitis media, propagation to the sinuses of the dura mater, thrombosis, with extension of the thrombus into the veins of the neck, the endocardium and the myocardium. This form of endocarditis has a special symptomatology, the pulmonary infactus leading one to believe that pulmonary tuberculosis is present. In this case the error was the more easily to be committed as the disease was not valvular but *parietal*, latent and without a souffle.—*Le Bulletin Médical*, No. 1, 1893.

GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D.

TREATMENT OF COMPOUND FRACTURES.—Treves recommends a method of treatment for compound fractures which he has used in his wards in the London Hospital in sixty-one cases during the past six years.

(1.) The limb is at once covered with lint soaked in carbolic solution, and subsequently carefully cleaned, protruding fragments of bone replaced, etc.

(2.) Ordinary wooden splints are employed, well padded, and held in place by fine webbing fastened by buckles, thus permitting tightening or loosening without disturbing the limb, as well as free inspection. Bandages or adhesive strips are deprecated.

(3.) The limb is kept throughout the treatment in the open air, the atmosphere under the bedclothes being particularly dangerous. In fact, all wounds of the lower extremities are kept out of the bedclothes in the writer's wards.

(4.) To allow free exit to blood and serum, and, at the same time, to prevent infection, iodoform or creolin powder is dusted freely over the wound, more being added as fast as any discharge comes through. A crust is thus formed which, when picked off at the end of a week, exposes a healed or healing wound. When the opening is in a dependent position, a quantity of powder is dusted on a wad of cotton and thus applied to the wound.

Eighty per cent. of these cases healed without suppuration, eleven suppurated, and five required secondary amputation.—*Annals of Surgery*.

FRACTURE OF THE RIB DUE TO COUGH.—Nash reports such a fracture in a man of fifty-four, who was recovering from a broncho-pneumonia. While swallowing some liquid food he was taken with a violent fit of coughing, fracturing a rib just below the angle of the scapula. Union followed under appropriate treatment. There was no apparent pathological predisposition to such an accident.—*Lancet*.

BONE SUTURE WITHOUT DRILLING.—Dollinger (Budapest) was led to use the following method in two cases of non-union in which the bone was either eburnated or so soft that the wire cut through. A piece of silver wire is passed around each fragment above and below the seat of fracture. These are joined by two loops of wire running longitudinally along the bone from one to the other. The fragments are accurately adjusted and the ends of the four pieces of wire twisted.—*Centralblatt für Chirurgie*.

TENDON SUTURE.—Dubrueil reports a case in which the superficial and deep flexors of the index-finger were divided with a piece of glass. The proximal portions, having retracted in their sheaths, could not be found, and so the two distal ends were stitched with catgut to the outer side of the flexor tendons of the middle-finger. Paralysis of flexion and extension followed, with atrophy of the forearm, probably from a neuritis caused by the constriction of the Esmarch tube for an hour and a quarter. Under the use of massage and electricity, function was restored at the end of two months to such a degree that the patient could play the piano, and was said to be able to flex the index independently of the middle-finger (!)—*Revue d'Orthopédie*.

TREATMENT OF PANARITIUM.—Schmitt (Munich) advises, in the treatment of felons, free incision, exposing all the involved tissue, under cocaine or chloroform anæsthesia, and after thorough disinfection of the skin. Such treatment should be instituted early, poultices and warm applications only helping delay to bring about necrosis of the tendon, phalanx, etc. The tendon sheath should usually be slit up, and, if the tendon present a grayish-green color, it should be excised as far as diseased, for it will only retard healing. In the after-treatment, dry dressings are preferable to wet applications, carbolic acid being particularly dangerous. They should be changed daily for a week.—*Münchener Medizinische Wochenschrift*.

THE VERMIFORM APPENDIX AS A CAUSE OF LONG-LASTING COLICS.—Hochstetter describes a case in which frequently recurring colicky pains in the right side

of the abdomen, with distension, constipation, and excessive sensitiveness to pressure, had lasted for nine years. On making an exploratory section, the appendix was found to be hard, swollen, spool-shaped, and non-adherent. It was removed, and the patient made a good recovery, being free from pain and inconvenience a year later. The appendix presented the characteristics of a chronic catarrh, the mucous and the submucous coats being thickened; this condition being an extension of a similar process in the cæcum, where it was undoubtedly due to constipation.—*Wiener Medizinische Presse*.

[Reports of such cases, with even less marked changes in the appendix, are increasing in number. The result of excision seems, however, to be an immediate cessation of all inconvenience. We recall two such cases:

1. Middle-aged female, subject to frequently recurring attacks of appendicitis, through one of which we had watched her. The leading symptoms were obstinate constipation, abdominal distension, rapid pulse, and inordinate, persistent pain, accompanied by tenderness, in the usual location. Section showed an appendix almost normal, aside from moderate catarrhal changes. It was excised. Fearing a mistake in diagnosis, the incision was enlarged and the gall-bladder examined. It was found to have undergone chronic inflammatory changes. An iodoform gauze pack was therefore used, the gall-bladder being suspended by a stitch, with a view to a subsequent incision. The symptoms disappeared at once and have not recurred, although nearly a year has elapsed.

2. Middle-aged male, who had suffered from a great number of similar attacks, was taken with symptoms of obstruction, rapid pulse, and agonizing ilio-cæcal pain and tenderness. The latter persisted obstinately. Section showed a moderately catarrhal, non-adherent appendix, and the right kidney on the brim of the true pelvis. The man has been free from all symptoms for two years.—Eds.]

TREATMENT OF INTESTINAL OBSTRUCTION AFTER LAPAROTOMY.—Klotz thinks this is due to the formation of adhesions between the small intestines and some cut or abraded surface. During the first few days these are easily separated. Increased peristalsis suggests itself as an efficient measure. Therefore, as soon as the diagnosis is made, the stomach should be washed out. If this does not relieve the symptoms the procedure is repeated, and about half an ounce of castor oil is poured into the tube. If attempts at vomiting are made, the patient is urged to retain the oil. Soon energetic peristalsis sets in and the vomiting and other symptoms are relieved. In two to three hours flatus is passed, and in about ten hours copious stools appear.—*Wiener Medizinische Presse*.

STOMACH LAVAGE AFTER OPERATIONS FOR INTESTINAL OBSTRUCTION.—Lund urges the importance of washing out the stomach before an operation for bowel obstruction can be considered complete. Three illustrative cases are given of strangulated hernia with stercoraceous vomiting, in which, at the close of the operation, the stomach was rid of a quantity of fecal matter by irrigation. There was no subsequent nausea or vomiting, and the cases made rapid, uninterrupted and afebrile recoveries.—*Lancet*.

TO PASS A BOUGIE THROUGH AN APPARENTLY IMPASSABLE STRICTURE.—The following procedure is recommended when the finest bougie will not pass a urethral stricture:

The urethra is distended with equal parts of a cocaine four per cent., and bichloride of mercury, one to one thousand, solution. This is kept in by constricting the penis behind the glans with the thumb and index-finger. The bougie or sound is then introduced, taking care that no liquid be permitted to escape. It is surprising with what ease the instrument will pass the obstruction, the result being due both to the infundibuliform dilatation of the urethral canal and the well-known action of cocaine in relieving the congestion.—*La Semaine Médicale*.

[We have met with equally gratifying results by the use of a two per cent. solution, or, better, emulsion, of cocaine in liquid cosmoline, to which three per cent. of carbolic acid has been added. The urethra is vigorously distended, the fluid being kept in by constricting the meatus with the thumb and fore-finger, reinforced by the middle- and ring-fingers at the base of the glans. In ten minutes *completa* anæsthesia is induced, without danger of toxic manifestations, and with marked anæmia. Besides its antiseptic effects, the carbolic acid mixes well with the fluid cosmoline, intensifies the anæsthesia, and modifies the toxic tendency of the cocaine.—Eds.]

GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D. AND J. NICHOLAS MITCHELL, M.D.

THE EXISTENCE OF CARCINOMA IN THE CERVIX AND CORPUS UTERI, SEPARATED BY HEALTHY TISSUE.—The fact that the above condition may occur is a powerful argument in favor of total extirpation of the uterus rather than supra-vaginal amputation in epithelioma of the cervix. Comparatively few cases have been reported, but enough to establish the fact of two separate carcinomatous growths in the cervix and corpus uteri. The second carcinoma is by metastasis from the primary growth or the result of inoculation from portions of the upper cancer lodging and developing in the cervix. The primary cancer usually is in the body of the uterus through the secondary or cervical cancer may appear more advanced macroscopically. The existence of two separate carcinomas, or double cancer, of the uterus can only be proven by a microscopical examination showing histological differences in epithelia and structure. Pfannenstiel who reports an interesting case of primary cancer of the body and secondary cancer of the cervix with intervening healthy tissue believes that no case has yet been reported of two primary and histologically distinct carcinomas of the uterus.—*Centralblatt für Gynäkologie*, No. 43, 1892.

SULPHATE OF COPPER PENCILS FOR TREATING CHRONIC ENDOMETRITIS.—Arnand employs pencils made of equal parts of sulphate of copper and rye meal with enough glycerine to mix and shape the pencils. After disinfecting the vagina and cervical canal, the depth of the uterus is measured by the sound and a pencil of the corresponding size is introduced and held in place by iodoform gauze. The patient is kept in bed for two or three days. A single application usually cures the case. This treatment is especially adapted to gonorrhœal endometritis. It is somewhat painful and the writer has given previously bromide of sodium or an enema with chloral.—*Centralblatt für Gynäkologie*, No. 43, 1892.

THE TREATMENT OF ILEUS POST-OPERATIONEM.—In five hundred and sixty-nine operations in which the peritoneal cavity was opened, Klotz lost five from ileus out of thirty-one cases; two out of six cases treated by secondary laparotomy were saved. He has had more trouble after antiseptic operations and very thorough toilette of the peritonæum than after aseptic operations without toilette of the peritonæum. He believes that ileus after operations is most often caused by direct or indirect mistreatment, and the epithelium is rubbed off some portion of the small intestine which comes in contact with a wounded surface and becomes adherent. Extravasations of blood particularly favor adhesions. The adhesions are easily broken by traction in the first few days, and separation may be accomplished by strong peristalsis of the intestines which can be excited by a simple and certain remedy. Washing out the stomach with from four to six litres of a warm salt solution is usually sufficient. If it fails, he washes out the stomach a second time and pours in fifty grammes of castor oil. If care is taken that the castor oil is not immediately vomited, energetic peristalsis of the entire intestinal tract begins very soon; flatus appears in two or three hours or at the longest in ten, followed by free fecal discharges. The vomiting ceased at once in all cases treated in this manner. The treatment must be commenced when the diagnosis is made. He administered the castor oil on the fourth or fifth day after the operation.—*Centralblatt für Gynäkologie*, No. 50, 1892.

PELVIC SUPPURATION, CHANNEL OF INFECTION IN.—Pelvic suppurations result most commonly from infection, travelling by two main channels—the first, taking the mucous route, and producing the various conditions known as vaginitis, endometritis, salpingitis, and pelvic peritonitis; the second, by way of the lymphatics, producing lymphangitis, adenitis, and phlegmon of the cellular tissue. This last was formerly thought to be the most common, but, since the times of Berantz and Goupil, and as a result of their teachings, the different varieties constituting the mucous-septic process until, by direct extension, the serous surface is reached, have been proved to be by far the most common.—F. Heurotin, M.D., *American Journal of Obstetrics*, October, 1892.

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY
CHAS. M. THOMAS, M.D.

COMMON SENSE IN THE TREATMENT OF DISCHARGES FROM THE EAR.—Dr. Duane presented to the Medical Society of Virginia a paper with this title. After showing the importance of the subject to the general practitioner, who was prone to slight it, he stated that the therapeutic principles which should be enforced here were the same that governed the treatment of suppuration anywhere else, which were comprised in cleanliness, drainage, and the removal of the badly diseased tissues. Common salt solutions he considered the best for the thorough cleansing of the diseased part. All details should receive careful attention, especially when committed to the patient himself, as they usually were. Politzerization to force out the residual discharge might be used as an adjuvant to syringing. If this treatment did not cure, astringent powders (boric acid, alone or combined with zinc oxide) should be used, but only after thorough cleansing by preliminary irrigation. Granulations and polypi must be carefully removed (of course with a good light and the patient under full control). Alcohol, with or without the addition of corrosive sublimate, could be used to check the recurrence of the granulations. Iodoform was useful in cases of caries. Unless there was extensive caries, or the drainage was prevented either by the situation of the disease (as in the attic) or by inflammatory hypertrophy, these measures would usually be successful. If they failed, the diseased parts (drumhead and ossicles) should be removed at once, and by a specialist, if possible, as the operation required great delicacy of manipulation. Dr. Duane believed that by following this treatment nearly all cases of chronic suppuration could be cured and the danger of cerebral involvement averted; also, that the necessity of doing a mastoid operation could be done away with altogether.—*New York Medical Journal*.

VASELINE IN MIDDLE-EAR DISEASES.—Delstanche (*Sem. Med.*, November 30th) speaks in high terms of the value of instillations of liquid vaseline in certain middle-ear affections. He says it has no bad effects of any kind, and he has discarded all other modes of treating plastic inflammations. It is also a most useful adjuvant to, and sometimes even a substitute for, paracentesis for the removal of accumulated secretions in the tympanum in chronic middle-ear catarrhs. In the first stage of acute median otitis, vaseline injections are said to relieve pain instantly, and to bring about recovery in five or six days. Delstanche adds, that the same treatment is of surprising efficacy in purulent middle-ear affections, especially if iodoformed vaseline be used.

SPONTANEOUS CURE OF COMPLETE SENILE CATARACT.—Mitvalsky collects all the published cases which seem well authenticated. These number eighteen, to which he adds notes of two cases recently under his own observation. As all these cases have been reported within a comparatively short time, Mitvalsky concludes that the spontaneous disappearance of senile cataract is not so uncommon as has generally been supposed. The changes which occur appear to be, in most instances, degeneration of the cortical layers of the opaque lens into a milky fluid, that is, the formation of a so-called Morgagnian cataract; this fluid cortex then becomes absorbed, leaving a shrunken capsule containing a hard nucleus of varying size, which sinks to the bottom of the sac of the capsule. In other cases, the fluid cortex becomes nearly or quite clear, and contains the opaque nucleus, which is frequently movable within the capsule. Sooner or later, this clear, thin cortex undergoes absorption. In a considerable proportion (6 out of 20) of the cases the changes in the cataractous lenses have begun after an attack of glaucoma.—*Centralblatt für Augenheilkunde*, October, 1892.

TUBERCULOUS ULCERATION OF THE PHARYNX TREATED BY LACTIC ACID.—Dr. Percy Kidd, of London, reports a case of severe tuberculous ulceration of the pharynx in a woman who showed symptoms of pulmonary tubercle, and with tubercle bacilli in her sputum. There had been diffuse ulceration of the back of the pharynx, the surface being pale and gray, dotted with bright red points like tubercles, and coated with a tenacious secretion. It was intensely painful, swallowing being almost impossible. The surface was thoroughly cocainized and lactic

acid was freely applied—first, in a solution of 50 per cent., afterwards the pure acid being used. It was only after fourteen applications that improvement ensued and evidence of healing was observed. Dr. Kidd had seen four cases cured by the lactic acid treatment.

LARYNGEAL PARALYSIS AFTER MEASLES.—In an epidemic of measles at Dharmasala, paralysis of the intrinsic muscles of the larynx occurred as a sequel in three cases. The cases were mild and had no respiratory complications or sequels except the laryngeal paralysis. The paralysis set in within a few days after the subsidence of the fever. The patients complained of no inconvenience except the loss of phonation. On laryngoscopic examination there was no congestion or inflammation to account for the matter. The rima glottidis remained midway between extension and contraction. Slight passive movements of the cords were visible on forcible respiration. The first case lasted about ten days (without any treatment); the second and third cases lasted about six days, treated with strychnine.—*The British Medical Journal*, November 19, 1892.

TREATMENT OF MARGINAL BLEPHARITIS BY MEANS OF A SOLUTION OF CORROSIVE SUBLIMATE IN GLYCERINE.—Dr. L. Borno recommends the application of a solution of corrosive sublimate in glycerine as the best treatment for blepharitis. It is the method employed by Dr. Despagne, of Paris, in the treatment of this troublesome affection, which is not easily controlled by the ordinary means at our disposal. It consists in painting the outside margins of the lids, close to the roots of the eyelashes, with 1 to 30 and 1 per cent. solutions of perchloride of mercury in glycerine.

The stronger solution is applied every second day *by the surgeon*, after the eyelashes and scabs have been removed. At the end of each application the part is dried with a piece of cotton-wool. The pain produced by the passage of some of the lotion into the eye is relieved by bathing with cold water, and is much less acute than one would be inclined to expect from the strength of the solution. This is due to the fact that corrosive sublimate, like carbolic acid, loses some of its causticity in glycerine.

The 1 per cent. solution is painted on daily *by the patient himself*.

According to Dr. Borno, the condition of the lids shows a marked improvement from the very first week of the treatment. A cure is obtained within two months, even in inveterate cases of blepharitis with thickening of the margins of the lids.—*The Medical Week*, January 13, 1893.

KERATO-MALACIA IN YOUNG CHILDREN.—Dr. Holmes Spicer read a paper on this subject before the Ophthalmological Society of London. He referred to young children as more liable to gangrene of the cornea than adults when their vitality was reduced below a certain level. The gangrene might either be spontaneous or the result of comparatively mild attacks of conjunctivitis. In the late stages of tuberculous meningitis, and in infantile diarrhoea, the cornea undergoes destruction; this being due partly to exposure and partly to insensibility. After measles or whooping-cough, with bronchitis and malignant varicella, where there had been much exhaustion, the cornea was not infrequently seriously damaged by large perforating ulcers. The affection generally attacks both eyes of children from four to nine months old; it begins with dryness of the conjunctiva, with patches of froth on its surface, and with night blindness; soon, the whole cornea becomes opaque and perforated, the termination being very often fatal. A principal feature of the treatment should be the increase of the nitrogenous constituents of the food, some meat-juice, or raw meat finely powdered, in addition to milk for young babies, and cod-liver oil. Locally, eserine in the form of an ointment should be applied to the eye, with warm applications to the lids.

In discussing this subject, Dr. Drake-Brockmann said he had met with many cases of kerato-malacia in India in times of famine, during epidemics of cholera, and not infrequently in association with chronic dysentery. He thought the condition in children was often associated with congenital syphilis. In many cases destruction of the cornea occurs with extraordinary rapidity. Dr. Priestly Smith (Birmingham) dwelt upon the necessity of keeping a careful watch upon the cornea of children and others prostrated by serious illness. The cornea is often exposed during sleep, and prone to severe ulceration. Protection of the cornea by a bandage, or adhesive plaster on the eyelids, will often prevent this dangerous trouble. Sometimes, even union of the margins of the lids is necessary.

MONTHLY RETROSPECT OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D., AND FRANK H. PRITCHARD, M.D.

ACALIPHA INDICA IN PHTHISIS.—This remedy Dr. A. C. Clifton prescribes occasionally for cases of incipient phthisis affecting the apex of one or the other lung without very marked pain there, but attended with a hard racking cough, generally worse at night, with very little expectoration, that little being tinged with blood, and sometimes with more pronounced arterial hæmorrhage, and yet without rise of temperature or other febrile disturbance, and for the most part occurring in pale, delicate individuals, with some amount of emaciation.—*Monthly Homœopathic Review*, February, 1893.

GASTRO-INTESTINAL SYMPTOMS OF ÆTHUSA CYNAPIUM.—Although the gastro-enteric symptoms of this drug, vomiting of undigested milk and the passage of the same by stool with greenish and yellowish evacuations, colic before stool, and tenesmus afterwards, point to a condition of gastro-enteritis, yet Dr. Clifton believes such an interpretation of the symptomatology of the drug is incorrect, but that the symptoms in question are merely the reflex of a brain disturbance. He has scarcely seen any benefit from æthusa unless the symptoms accompanied brain disturbance and convulsions, and mostly occurring in young children during dentition, generally with the eyes drawn downwards, the pupils dilated, and the fingers and thumbs clenched. When the brain symptoms have not been accompanied by the gastro-enteric symptoms, the remedy has not done Dr. Clifton service.—*Ibid.*

HEAD SYMPTOMS OF ÆSCULUS HIPPOCASTANUM.—In all the cases in which this remedy was beneficial, torpor and congestion of the liver and portal system, with constipation, were prominent. The most marked symptoms of the head were a sensation of fulness with constriction, throbbing, shooting pains, sometimes in one part, at other times in a different part, with a somewhat muddled feeling on mental exertion, the pains extending from the occiput to the frontal region and to the eyes, with a bruised sensation in the scalp, all being worse as a rule in the early morning after heavy, dreamy sleep.—*Ibid.*

ACTION OF ÆSCULUS IN THE MOUTH, FAUCES AND POSTERIOR NARES.—The prominent symptoms have been heat, dryness, sense of rawness, pricking and smarting, shooting, stitching pains up to the ears when swallowing, sometimes constriction and difficulty in swallowing dry food, and soreness of the throat and gums. The throat symptoms, representing follicular pharyngitis, while sometimes resulting from a chill, are nevertheless generally connected with hepatic congestion already alluded to; when, however, they are due, as they sometimes are, to indulgence in tobacco and alcohol, *nux vomica* and *kali bi.* will do more good. Referring to the symptoms of the stomach, liver and abdomen, generally "weight as of a stone in the stomach" is most manifest three or four hours after a meal, and attended with a gnawing, aching pain and yet with inability to take an ordinary meal.—*Ibid.*

ACETIC ACID AND ANÆMIA.—In the case of a young woman who had taken freely of vinegar to improve her complexion, it had produced a very pronounced anæmia, with some amount of anasarca, great debility, frequent faintings, a weak and faint action of the heart, dyspnoea on exertion, vomiting of food, with tenderness over the epigastric region, and frequent watery stools. These symptoms from the vinegar habit are usually cured by *arsenicum iod.* 2x, *strychnia ars.* 6x, *apium virus* 3x, and *natrum mur.* 6x. In cases with similar symptoms not due to the vin-

egar habit, *acetic acid* 1x has been of signal service. The keynotes for this remedy appear to be anæmia, with anasarca, great debility, vomiting of food, epigastric tenderness, frequent watery stool, more especially in the early morning, together with excessive catamenia.—*Ibid.*

MENTAL SYMPTOMS OF ACTEA RACEMOSA.—The mental condition of this drug is largely marked by great depression of spirits with dread of impending evil, intense restlessness of mind and body, desire to mix with others and yet choosing solitude and rest, a wish to go to church or a concert but with fear of being obliged to rush out from the building; during a ride in a close carriage, by rail or otherwise, there is the fear of being obliged to jump out, while a ride in an open carriage is agreeable. Especially are these symptoms characteristic when they are accompanied by a wild feeling in the brain, full and pressing out, shooting and throbbing pains in the head occurring about the same time daily, and for the most part relieved by pressure, rest, and open air, and more especially when the symptoms are the result of mental worry or over-study, or been the reflex of uterine disorders in women.—*Ibid.*

ACTEA RAC. IN ASTHENOPIA AND ASTIGMATISM.—In these conditions, accompanied with deep-seated throbbing and shooting pains in the eyes, with photophobia from artificial light, and when brought on by overstrain of the sight in anæmic and debilitated subjects, actea has been eminently serviceable.—*Ibid.*

ACTEA RAC. IN DYSMENORRHOEA.—In dysmenorrhœa, it is Dr. Clifton's experience, that actea is the most useful when the pain immediately precedes the period, and ceases in a day or two. The muscular and crampy pains occurring in nearly every part of the body are characteristic of actea. It is especially beneficial after a few doses of aconite, and when the pains are somewhat relieved by rest. The dose is two or three drops of 1x dilution.—*Ibid.*

NERVOUS SYMPTOMS OF AGARICUS MUSCARIUS.—A keynote of this drug in chorea is the "nervous twitchings and spasmodic muscular actions cease during sleep." Dr. Clifton has cured several cases of chorea with agaricus in which the muscular twitchings did not cease during sleep. Dr. John Drysdale was the first who pointed out some symptoms of agaricus resembling the delirium of typhoid, and in which he prescribed the remedy with great benefit. Dr. Clifton has employed agaricus in a few cases presenting similar symptoms to those already noted, and for the most part with good results, while in congestion of the brain with delirium from large doses of alcohol it has frequently done good.—*Ibid.*

HEAD SYMPTOMS OF AGARICUS.—The most characteristic symptoms are sensation of fulness and pressing outwards, both in the occipital region and extending to the forehead and glabella, relieved by bleeding from the nose, which sometimes takes place, and at the same time with a sensation of coldness of the scalp and the desire to cover the head warmly; the delirium is characterized by singing, shouting, and muttering, and is often attended with twitching of the muscles of the face.—*Ibid.*

AGARICUS IN ASTHENOPIA.—Dr. Clifton has cured many cases of asthenopia with agaricus when there was great uncertainty and irregularity of reading power, and attended with vertigo when walking and in the open air.—*Ibid.*

AGARICUS IN ITS RELATION TO THE STOMACH, LIVER, AND SPLEEN.—The main symptoms are characterized by fulness and congestion. In old toppers, especially whiskey and brandy drinkers with hypertrophy of the liver and attended with much flatulence in the stomach, loud and spasmodic eructations of wind, like unto the hysterical eructations occurring in women from other causes, Dr. Clifton has seen agaricus do much good. So, too, when there has been much flatulence, distension of the abdomen from flatulence, with rolling, gurgling sound, it has been useful. In diarrhœa from indulgence in spirituous liquors, when the stools are greenish, yellowish, bilious, and sometimes bloody, with flatulence, and occurring, for the most part, early in the day, agaricus has been of great service.—*Ibid.*

KEY-NOTES OF AGARICUS are, according to the experience of Dr. Clifton, nervous and muscular spasms in nearly every part of the body, more especially on the left side; great sensitiveness to touch; creeping, pricking, and tingling sensations in

various parts; a general chilliness and dislike to cold air; sensation of coldness of the scalp in cerebral affections; general congestions, with defective circulation and a weak, slow, and irregular action of the heart; desire for alcohol, which being given, affords temporary relief.—*Ibid.*

HOMŒOPATHIC TREATMENT OF LUPUS.—Dr. V. Léon Simon, of Paris, considers the homœopathic treatment of lupus slow, the remedy must be carefully chosen, rarely changed, not too often repeated, and given in a minute dose. Do not spoil the case by too frequent repetition. The drugs corresponding to all the phases of the disease are thuja, sepia, graphites, hydrocotyle and lycopodium.

Thuja presents in its pathogenesis all the elementary lesions of the lighter form of the disease. It is characterized by spots upon the neck, "liver-spots," with reddish elevations, small scurfy spots and many little warts. An eczematous and reddish brown eruption appears upon the back of the neck and chest. Most of the eruptions of this drug are surrounded by more or less pronounced and reddish areola. It is a true specific in the vegetating or hypertrophic stage of the disease.

Dr. Clark, of London, said in 1888, that for three years he had treated all his lupus patients with this remedy, giving it internally and externally.

Dr. Malapert du Peux, of Lille, France, also claims numerous successes with thuja. It is one of the principal remedies, and especially indicated in scrofulous patients. Its eruptions are chiefly on the left side, the patient's state aggravated by menstruation, by cold or by excessive heat and heat of the bed, fatty meats, onions, sour things, sweets or sugars, wine, beer and tea. Also if there is a history of excessive use of tobacco, sulphur or mercury. Pernicious growths and the deformation of the fingers often seen in phthisical patients and the creoles of South America.

Sepia.—Indicated in the initial period when the macules predominate; cutaneous pigmentations. In short when there are scurfy spots, tubercles, ulcers, especially has this remedy a predilection for the face and nose. When the affection is aggravated by cold and dry air, snow, sexual excesses, pregnancy, and nursing it corresponds to young girls or women, with fine and delicate skins, with reddish spots, alternate hot and cold sensations and, either uterine, respiratory or intestinal symptoms. Sepia and thuja he regards as the specifics in vulvar lupus—*esthiomène vulvaire*.

Graphites.—This remedy has many features in common with sepia. It is to be preferred when the disease occupies other regions than the face. Its value is attested both by its pathogenesis and clinical experience. It is especially indicated when the subject is a dyspeptic, inclined to constipation, if the skin suppurates easily, when the disease occupies the left side of the face and is filled with blackish dots. The glands easily take on induration, often observed in scrofulous patients; finally, it suits leucorrhœic patients and those with retarded menstruation. If the disease has appeared after suppression of the menses it is especially to be thought of, or, if the patient suffers from a respiratory affection, alternating, possibly, with the skin disease.

Hydrocotyle Asiatica.—This drug is praised by some and rejected by others, yet it certainly has an affinity for lupus, but therapeutically it is inferior to the preceding.

Lycopodium.—The indications are: eruption of a coppery color upon the forehead; reddish spots, which itch or burn. Large warts, exuding a scanty fluid; eruption covering the whole of the right cheek, which is thick, dry, and crust-covered and itching; a special inclination to have an eruption upon the left cheek.

Recent lupus.—If the lesion occupy the right side, the patient has had a liver disorder or circulatory disturbances of the portal system, the remedy is the better indicated. Irritability of character, deafness, with purulent otorrhœa and all sorts of dyspeptic symptoms.

I. *Special Remedies for Various Periods or Forms*.—*Macular Period*.—*Natrum Carbonicum*.—This drug, though but little used by homœopaths, has a broad pathogenesis from Hahnemann's time. The patient has yellow macules upon the forehead and upper lip; the skin is dry; there are warts, erysipelatous tubercles, and tubercles upon the thighs. The cutaneous manifestations of this drug are numerous and prominent. It is to be employed when the patient has macules and excrescences upon his face, especially if he be dyspeptic and of a delicate constitution. There is a disposition to take cold; the feet are cold; there are lassitude, sweats, great laxity of the ligaments, prostration of mind, profuse nocturnal micturition, seminal emissions, and other signs of a profound deterioration of the organism.

II. *Tuberculous and Hypertrophic Period*.—*Silica and Arsenicum Iodatum*.—Prof.

Franklin, of Michigan University, recommends these drugs, using them in the third centesimal trituration. They correspond both to the scrofulous diathesis; the children have an enlarged abdomen, with weak legs; sweat profusely on their heads when silica is indicated. The iodide of arsenic is indicated in advanced and cachectic states, but the writer prefers thuja to either of these.

III. *Exfoliative Stage*.—*Mezereum*, *arsenicum*, and *phosphorus*.

Mezereum.—This drug is characterized by the presence of thick or lamellated crusts. It is more closely indicated in subjects previously syphilitic, or who have been mercurialized.

Arsenicum.—This is pre-eminently adapted to the squamous form. It produces pustules, ulcers, and desquamation in large lamellæ. Hering claims it to be indicated in persons with liver-spots and in whom the skin, covered by the clothes, is of a dirty brownish or earthy color, as if it were washed. Hectic fever and signs of tuberculosis are other indications.

Phosphorus.—This remedy is prescribed by Kafka in increasing doses. It has cured a case of exfoliative facial lupus. The writer thinks it more indicated, like arsenic, in cancerous and gangrenous affections. If the patient be in poor health, with tuberculous symptoms, or is rachitic or had osseous rachitic lesions during his youth, it might be of service.

IV. *Ulcerative Stage: Lupus Exedens*.—*Causticum*, *calcareæ carbonica*, *cistus*, *kali bichromicum*, *hydrastis* and *aurum muriaticum*.

Causticum.—This drug produces pediculated or sessile verrucous growths and chronic dermatoses; ulcers, with corrosive secretions upon the hands, fingers, or toes. Ulcers upon the left side of the nose near the nasal aperture. It is especially suitable to hæmorrhoidal subjects or hypochondriacs who suffer from sadness or anxiety or who are inclined to attacks of dyspnœa with chilliness, heat and sweat, and involuntary micturition during coughing and sneezing. Clinical experience has confirmed these expectations.

Calcareæ Carbonica.—Besides the skin symptoms there are: a tendency to osseous affections; puffiness and flabbiness of flesh; tendency of the skin to suppurate and heal slowly after the slightest injury; increased size of the abdomen; anorexia; the menses are too frequent or abundant, and there is leucorrhœa. Three clinical cases are cited.

Cistus.—This remedy is of the greatest importance in purely scrofulous lupus. It is characterized by chilliness, both objective and subjective. The patient is aggravated by the cold air; his feet, fingers, etc., are cold, even when in a warm room; sensation of cold in the nose, in the throat, in the stomach, after a meal, in the whole abdomen; the breath is cold; fever, in which the cold and sweat predominate; sore throat from breathing the least cold air; oppression and creeping over the entire body from cold air. It has a great affinity for the glandular system, for under its influence the mammary glands, the thyroid, cervical, lymphatic, and those of the pharynx enlarge and proceed nearly to suppuration. The intestinal glands are also involved, with diarrhœa, and functional disturbances of chronic dysentery result. Lupus of the face and lupus exedens of the mouth and nose. No other remedy is so characteristically affected by cold.

Kali Bichromicum.—This remedy corresponds to non-progressive erythematous lupus of the seborrhœic form, and to lupus vulgaris of the mucous membranes. Its localizations are those of lupus erythematosus, and it exercises an elective action upon the sebaceous glands and the mucous membranes. The mucous secretions become stringy or purulent.

Hydrastis.—This drug is indicated in scrofulous and cachectic subjects. It gives a yellowish tint to the face, produces indolent and granular ulcers, with a scanty and unhealthy pus. It gives rise to ulcers upon the nose and eyelids, with a (dark) reddish-yellow base, which is dry, non-granulating, and secreting, but little. The lower limbs are also attacked and become covered with superficial ulcers of roundish contour, dry, foetid, with a yellowish crust, burning and lancinating pains, an inflamed areola, and covered with nodes, which easily degenerate into ulcers. It also affects the hairy scalp.

Aurum Muriaticum.—This remedy corresponds best to syphilitic lesions and to mercurial intoxication. It is not adapted to purely lupous cases; rather in those suspicious or doubtful cases and those certainly syphilitic.

V. *Erythematous Lupus*.

1. *Purely Erythematous Variety*.—*Belladonna*.

2. *Erythematous and Rosaceiform Variety*.—*Lycopodium*.

3. *Pityriasisiform or Psoriasiform Variety*.—Arsenicum and cicuta (?).

4. *Centrifugal Erythema of the Common Variety*.—Sepia and thuja.

5. *Non-Progressing Lupus Erythematosus*.—Kali bichromicum, graphites, baryta carbonica.

The latter is only indicated when the lesions occupy the ear or the hairy scalp. Among the other remedies which have occasionally been employed with success are: iodine, creosote, mercurius corrosivus, apis, nux juglans, bignonia catalpa, ozenine, and staphisagria.

No one remedy will correspond to all the phases of a single case. Whenever the ulcers become converted into ordinary cicatrizing wounds, the remedy should be suspended and the drugs covering the indications of the moment be given: *hepar sulph.*, followed by *silica*, if there be abundant suppuration; *belladonna*, followed by *mercurius solubilis*, when there is inflammatory reaction; and *nitric acid* when there are exuberant granulations. If complications arise, drop all remedies and combat them. Tuberculosis is the most frequent. The chief remedies are here: arsenic, phos., calc., creosote, iodine, sulph., kali carb., *hepar*, and china. In a strumous or syphilitic lupous subject we may alternate; in the vegetating form, thuja or arsenic iod., with nitric acid, etc. Regard is to be had to heredity in prescribing. The dosage varies: in slowly progressing forms, give higher dilutions; in syphilitic subjects, the lower ones or even the crude drugs.—*Revue Homœopathique Française*, No. 5, 1892.

CLINICAL OBSERVATION OF THE ACTION OF PHELLANDRIUM ACQUATICUM ON PULMONARY TUBERCULOSIS (caseous form) —I have been using this drug for the last fourteen years, particularly for those cases of tuberculosis affecting generally the middle lobes of the lungs, where solidification has remained after attacks of pneumonia or pleuro-pneumonia, or when the disease has started spontaneously in those regions without any other ætiological factor than a mere predisposition to the disease. I am inclined to think, however, that preceding attacks of malarial poison by deeply debilitating the system have been the proximate cause to kindle in the lungs the spark of a hereditary or latent tuberculosis, and that phellandrium is the better indicated remedy for these particular cases. The group of symptoms subdued and cured by phellandrium is the following: Solidification or chronic hepatisation of the middle lobes of the lungs, generally on one side, with or without a cavity; the physical examination revealing the signs of a first or second stage of phthisis, fibrous phthisis, or caseous pneumonia of the German authors. A regular intermittent attack of hectic fever, characterized by a shaking chill or chills, in the morning or forenoon, followed by heat, which increases as the night comes on to 101° or 102° F., and ending in a profuse and debilitating perspiration, with almost normal temperature in the early morning. Persistent cough, sometimes dry, but often with profuse and foetid purulent expectoration, if there be some softened foci in the hepatised region of the lung. Dyspnoea and a tired feeling when walking. General emaciation, sometimes very rapid. Anæmia, debility, loss of appetite, great thirst, irritable disposition very marked, frequent headache, and sometimes diarrhoea. I generally prescribe the tincture of phellandrium, or the first decimal dilution, from two to five drops three times a day. The result is usually most satisfactory, for all those symptoms disappear or are so modified as to bring complete relief to the patient in four or six weeks. The physical signs revealed by percussion and auscultation of the tuberculous process will be found to diminish and modify themselves *pari passu* with the fever, expectoration, dyspnoea, etc., placing the patient in such a favorable condition that the cure can be completed by living most of the time in the open air, aided by iodide of arsenic, calcarea hypophosphorica, iodoform, or guaiacol, if there still should remain an unhealed cavity in the lung. In other cases of tuberculosis of the apices, or in acute miliary tuberculosis, phellandrium has not reduced nor modified the hectic fever, neither produced any favorable impression in my hands for the other symptoms, proving once more that each remedial agent has its particular and specific sphere of action under certain and determined circumstances, and no more. In the *Hand Book of Materia Medica*, by Dr. T. F. Allen, the clinical observations of phellandrium are as follows: "Bronchitis and emphysema, with rapid respiration, cough compels him to sit up day and night, with sleeplessness and ulcers on the legs, with tearing, sticking pains." "Valuable for the extremely offensive expectoration in the last stages of phthisis." "It has been prescribed in intermittent fever, with pain in the arms." I hope that others will verify in their practice the symptoms

which I have pointed out to be cured by *phellandrium aquaticum*.—J. A. Terry, M.D., in the *North American Journal of Homœopathy*, February, 1893.

TREATMENT OF ARTERITIS.—Dr. P. Jousset, of Paris, though admitting that the majority of gangrene cases are due to arterio-sclerosis, yet states that some are dependent upon inflammation of the nerve-trunks distributed to the extremities involved.

Iodides of Sodium and Potassium.—These are of the same importance in the treatment of gouty arteritis as of arterio-sclerosis. These may be said to be the principal remedies. They should be continued during the intervals of the paroxysms which characterize the progress of the disease. The dose is the same as that in arterio-sclerosis.

When the gangrene sets in the following remedies may be employed: arsenicum, lachesis and, especially, ergot.

Arsenicum.—This remedy comprises all the symptoms of inflammation of the arteries. It is principally indicated when the pain is excessive, intolerable, burning and nocturnal, and when the swelling is hard, violet-colored and greenish, especially in case a foot is attacked. The first few triturations, repeated every two to three hours.

Lachesis.—Lachesis like the other poisons is also a remedy covering arteritis. The gangrene of this drug is accompanied by purpura hæmorrhage and œdema. The sixth is the attenuation which he usually prescribes.

Secale Cornutum.—This drug is most homœopathic to gangrene of the extremities. The gangrene is most frequently dry, resembling entirely the senile form; it is preceded by cramps, deep-seated pain, lowering of the local temperature and other symptoms described under *asphyxia of the extremities*. The disease is limited to a single extremity or is symmetric and in both limbs. The arterial pulsations cease to be perceptible. The lesion accompanying poison by ergot is arteritis. The vessels are obliterated by thrombi and sanguine concretions. The first few triturations repeated every two to three hours.—*L'Art Medical*, No. 1, 1893.

LIATRIS SPICATA.—A Remedy for Chronic Diarrhœa.—*Liatris spicata* or "button snake root" grows wild in Wisconsin. Dr. A. E. White calls attention to its reputed virtues in chronic diarrhœa. He uses the remedy in the 1x or 2x. To illustrate its action in these troubles, he cites the following case: Mr. —, banker, æt. 56 years, has had chronic diarrhœa since the late war. Of late had been having from twelve to sixteen passages a day, and had fallen from 180 to 120 pounds. He was given two doses of sulphur 30x, a dose to be taken each night on going to bed. This was followed by merc. cor. 3x, a dose on retiring for five days. He was then given *liatris* 1x on pellets, four pills to be taken on retiring. This was followed up for five weeks, at the end of which he was as well as he ever was in his life, and has continued so to this day.—*Minneapolis Homœopathic Magazine*, January, 1893.

DUBOISIA—Dr. George G. Shelton recommends *duboisia* in pharyngitis sicca with black, stringy mucus.—*Chironian*, January 25, 1893.

LARYNGEAL SYMPTOMS OF ARGENTUM MET.—The laryngeal symptoms of *argentum met.* are marked by rawness and soreness on coughing, the voice is hoarse, and the expectoration is viscid, not stringy, slightly gray in color, jelly-like or similar to clear boiled starch. The soreness is present when coughing, but absent on swallowing. It is an admirable remedy for the laryngeal troubles of public speakers and singers.—*Chironian*, January 25, 1893.

ARGENTUM MET. IN BLEPHARITIS.—*Argentum met.* is indicated in blepharitis when the margin of the eyelid is greatly thickened, but never in the purulent form. *Argentum nitricum* produces a violent inflammation of the conjunctiva, associated with great swelling and purulent discharge; this condition is accompanied by the sharp sticking pains so characteristic of nitric acid and all its compounds.—*Chironian*, January 25, 1893.

HYDRASTININ HYDROCHLORATE IN HÆMORRHAGE.—S. H., aged 27. She had suffered with bleeding from the bowels and slime in the motions, as she expressed it, for two years. This hæmorrhage, sometimes considerable, occurred whenever bowels acted; motions were constipated and covered with mucus; dysmenorrhœa. *Hamamelis* and *thlaspi* failing, *hydrastinin* cured in one week.—Dr. Neatley, *London Homœopathic Hospital Report*, December, 1892.

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OUR MATERIA MEDICA.

BY JAMES G. GILCHRIST, A.M., M.D., IOWA CITY, IOWA.

(A Lecture delivered before the Hahnemannian Society of the University of Iowa.)

ONE who, for many years, has had close connection with homœopathic therapeutics, can scarcely fail to be impressed by the attitude of different classes of people towards us as a school and as individuals. Our history has been somewhat unique, and the favor and privileges we now enjoy may justly be attributed to these peculiarities. In what respect, it may be asked, does our history differ from the ordinary history of new theories that prove to be expositions of fact? In none, in general, and much in particular. In the history of inventions, the development of useful arts, the evolution of scientific truth, the course of events has been very similar to the main features in our history. But in the history of medicine it is, in some respects, unlike anything that has gone before. The central idea in homœopathy is, of course, the law of similars; not *a* law, one of many, but *the* fundamental law of therapeutics. Dose and *potency* are purely subsidiary, unessential, and yet seem to be natural resultants. The law, being a law of nature, of course existed from the beginning of time. I have no purpose to expound that law, nor disposition to argue for it; it seems to me quite as unnecessary as to defend the law of gravitation, or any other equally established

law of physics. Certainly, in this presence such a discourse would be a simple fighting of the wind. We must start out with the concession that the law is unquestioned. Notwithstanding the fact that the law had been in operation in the forces of nature from the commencement, it was not fully recognized until HAHNEMANN pointed it out in his celebrated ORGANON. At various times in the history of medicine a suspicion or hint of its existence became visible, but it soon disappeared only to come up again in a later age. Now, so far, its development or proof of legitimacy has been along the same lines with the establishment of any medical fact. But here comes in the singular fact. Heretofore, when any attempt has been made to found a "school" of therapeutics, while the originator has secured multitudes of followers during his lifetime, the "system" has never outlived its founder. More than this, no other attempt has ever been made to discover or formulate a law of therapeutics general in its application. Now with us, as is well known to all of you, not only has there been no falling off in the number of adherents since Hahnemann's death,—rather a constantly increasing accession,—but the law he formulated has been found of wider and wider application until none who have seriously investigated the subject have failed to give in their adhesion in greater or less completeness. We know, even in what they call the "regular" school, medical practice has been greatly modified by a partial recognition of what must stand as one of the great truths of nature. Certainly, then, our history is unique, and, judged by the history of medicine in general, the time will surely come when the name of Hahnemann will be found in the same roll with Harvey, Jenner, and Vessalius, who all met with similar treatment from their cotemporaries during their lives. Such a history means very much; more particularly, to sum it up in a single word, *verification*.

Remembering that the single and controlling idea in homœopathy is the law of similars, it follows that the one element responsible for our reputation, and the esteem we enjoy, is what is called our *materia medica*. The proving of remedies on the well, and their verification on the sick, is the peculiar province of homœopathy. Nothing that we have done or may do in science, in literature, or in the laboratory has or can add to, or even confirm, our reputation. It has been made solely by the knowledge of drugs we have acquired by proving them on the well, and confirmation of this knowledge by clinical experience. And this suggests another thought, and one upon which I wish to lay particular emphasis. It is the *pure* homœo-

pathic therapists that have given us character and position. The labors of Hahnemann, Boenninghausen, Hering, Lippe, Raue, Guernsey, and many like them, is what we have to acknowledge as our sources of power. Without them we would never have seen our system recognized by press, courts, and people; our colleges fostered by the state, as in Michigan, Iowa, Minnesota, and Nebraska. State Boards of Health, compelled by law to give us representation on their Boards of Medical Examiners; State Asylums for the Insane given to us; and the public charities generally thrown open to us. Where or when, in the whole history of medicine, has a body of men, forced into a sectarian attitude, as we have been, received such recognition? Has it not always been the case that such sectarian characters have inevitably led to extinction? If our present position is due to the pure therapeutics of our predecessors, are we not justified in hoping for its continuance only by similar means? If in after life, when you have finally entered the professional fraternity, you find either through ignorance on your part, or what seems to you insufficiency in our peculiar methods, that other methods or systems of practice give you better results, why, in justice to your clients, give them that which your experience teaches is best for them, but, in justice to yourself, in obedience to the dictates of common honesty and manhood, do not continue to call yourself a homœopath. I am as certain as I am of anything that a failure to secure results, promised and expected, must always be attributable to a deficiency in ourselves,—none in the law. If the law is inconstant, it is no law. Once, when complaining to Dr. Lippe that a certain remedy had utterly failed, and the law seemed a little broken, he replied: "No; the failure is because you have not given the right remedy." I fancy many of these failures we read about are failures of this kind.

The great achievement, the one that justifies our existence, is this enormous mass of symptoms comprised in our *Materia Medica*. If we had done nothing more, if we had never verified, clinically, the relation of these symptoms to disease, nor thereby established the fact of the legitimacy of our law, this record, secured by such expenditure of time, patient research, and much actual physical discomfort, if not positive suffering, should entitle us to the gratitude of the world. Do you know that it is the only record of the action of drugs extant? In former times, and, indeed, to-day as well—there were and are but two sources of knowledge of drug-action, outside of our household. One of these, is a study of cases of poisoning, in the

case of human beings and the lower animals (either accidental or designed), and the supposed effects of drugs when given to the sick. It cannot be necessary to point out, in detail, the insufficiency, or worse, of such testimony. The sources of error are so numerous, and the record of symptoms so meagre, that nothing of therapeutic value can be had. But in our record of "provings," as we call them, we have a systematic, complete, and authentic account of drug action, not to be found elsewhere. In fact, if the whole theory on which our therapeutics is based were proved to be false, and the law of similars entirely misconceived, the record of drug pathogenesis we have compiled would stand as a monument commemorative of as unselfish and humanitarian self-sacrifice as the scientific world has ever seen, to say nothing of its value as a contribution to exact science.

While all this is unquestionably true, all of you who are studying *Materia Medica*, I doubt not, feel very much as your predecessors did, and most ardently wish there were less of it. In the present state of knowledge it is, or seems to be, impossible to strike out a drug, eliminate a line or change the form of an expression. As we learn more about the source and significance of symptoms, we shall certainly vastly abbreviate and simplify the symptomatology. It is very doubtful if we ever shorten the list of remedies; in fact, the probabilities are that it will even be lengthened. The difficulties we meet with in studying this immense subject, are due to two conditions: ambiguity in language, and irrational arrangement. Ambiguity is partly due to the fact that the earlier provers knew comparatively little of pathological processes, and the terms they used have been copied and re-copied by countless compilers, because there have been very few original workers in this field. It is also partly due to want of knowledge of the meaning of symptoms, both in the original provers, and their followers. For instance, as an illustration on one side—take the word "immobility"—that is found so often in connection with the joints. What does this mean? Is it ankylosis, or paralysis, or contraction, or contracture, or voluntary from causing pain when motion is attempted? The books do not say, many of them even give no hint on which one may hang an inference. So also with "swelling;" is it exudative, parenchymatous? new tissue, or hypertrophy? We can put this down as an axiom, to be returned to later: Every effect, has a specific cause; in other words, every unmodified symptom has a single origin and producing cause. This might be carried a little farther, as every mor-

bid action, no matter how trivial or ephemeral, must have a central, controlling lesion, due to a specific cause. Now, if this is true,—and it certainly seems to be,—there are multitudes of symptoms, so-called, that are really secondary to the essential group, with no significance whatever, either as guides to a remedy, or an aid in diagnosis. All such, of course, should be eliminated. But who is to decide which these are? Ah! there is the difficulty. Until we know more about the source and meaning of these symptoms, in other words, have a definite, scientific and accurate knowledge of pathogenesis, no man dare touch them. Possibly some symptoms, now apparently inconsequential, may later be found of first importance, and others degraded to a lower rank.

This leads us to the second point, namely, the *irrational arrangement*. Of course, when symptoms appear in a proving, they do not do so in the anatomical order familiar to us. Some one symptom must appear *first*, and others must come in regular order. When multitudes of provings invariably give a certain symptom as the first, it is rational to suppose that it must represent the initial lesion. It ought to go without saying, but it is vehemently disputed—that there can be no symptom without a lesion, gross or minute. Every drug must have the power of producing an initial lesion, its *own* and no other. With this determined in every case a great step would be made. Then the succeeding symptoms, or secondary lesions, if you prefer, would be identified, one by one. After numerous verifications, re-provings and scientific analysis, it would soon be possible to have an accurate symptomatology of the drug, which would have the merit of eliminating all symptoms that are accidental, unimportant, and are common to other, sometimes many drugs. Each drug would then stand by itself, unlike any other; the initial lesion being at once recognized, all the succeeding ones can be foretold. Of course, the way our symptomatology is arranged, there is no index to the initial lesion. Therefore, the old anatomical rubrical method must be dropped, and one showing the sequence of symptoms take its place. Also, of course, this would be utterly impractical if the mass of symptoms we now have are to be retained. Therefore, revision must first be had, and it is becoming, after such a sweeping criticism as I have made, to suggest a feasible method.

You have often been told that there are two classes of symptoms, the objective and the subjective—those which can be appreciated without the aid of the patient and those which are actual sensations,

for which you must take the patient's word. I think it is a good rule to reject all subjective symptoms that are contradicted by objective. In getting what we call the "totality" of a case, do we mean all the patient has to *tell*, or all that we can see, hear, feel, smell, or taste? Neither, alone; but if only one, surely the latter. In short, to get a perfect picture of a case as a perfect picture of *any* thing, we must have every detail, all that can be procured by both the methods indicated above, and supplement it by all means that present themselves. It seems to me that if the objectivity of a case is the picture desired—and it would seem that there should be no question about it—we must use all means to increase them in number and intensity. The various diagnostic instruments of precision, the ophthalmoscope, rhinoscope, laryngoscope, stethoscope, sphygmograph, microscope, spectroscope, thermometer, urinalysis, and chemical and other tests of all the secretions must all be used in every proving until the knowledge of the drug is as absolute as the nature of things will admit. Here is work laid out for generations possibly, but work which must be done if an ideal *materia medica* is to be constructed.

This brings us to the main issue. Who is to do this work? You, and those like you, who profit by the work done by those who have preceded you. For many months you have been recipients of the best your teachers have to give. As far as time permits and the capacity and knowledge of your teachers extend, you have been put in possession of the accumulated learning of the profession. There is no book that you may not open, no knowledge that has been wilfully withheld. And is not this knowledge for use in your warfare with disease and death, a warfare that has already added years of life to the race, banished entirely some of humanity's former enemies and vastly mitigated human suffering. If I could believe that you seek admission to this noble profession, of which I am but an humble representative, solely for the personal gain that may be yours, I would never stand here as a teacher again. I believe you want to do *good* in the world, *all* the good you can, and I deem it a privilege to have the opportunity to point out one way in which you may do so. Let each one of you make one remedy your study. It is not too much to give your life to a single drug, clinically and experimentally seeking for its exact, complete, scientific pathogenesis. What *could* we not do, judged by the almost wonderful results already secured by the imperfect symptomatology we now have, if this in some sort chaotic mass of apparently unrelated symptoms could

be brought into order? If a physician detected the initial lesion and, noting the order of progression, could determine whither the process was inevitably tending, and at the same time see, as plainly as one's face is seen in a mirror, the *similimum* that would stop the current where he found it, and turn it back into its normal and orderly course, who would doubt that they who put such power in his hands had placed the whole human family under obligations? We are in debt to our professional ancestors—a debt of honor. There is but one way in which it can be paid, and that is in carrying on the work they so nobly began, doubting not that our descendants will still find work to do—finishing work that we lay down unfinished—until, it may be, disease itself will exist only as a memory.

But here comes in a grave difficulty. Admitting the imperfections in our *materia medica*, and also accepting my proposition for their amendment, what are we to do during the long space of time that *must* elapse before the completion of the work? We older ones will have to go on as we have, and you younger ones must be content to go over the same ground we have so long trodden. Most of us have, by stress of circumstances, been compelled to work out varying systems of study for mastering a sufficient amount of this vast material for our daily use, and it may not be without value to give you, of course briefly, an outline of my own method, now used for some thirty years.

Of course your professor of *materia medica* is particularly competent to tell you all this with greater authority and, doubtless, in better form than I am. I will not intentionally trench upon his province, partly as an act of courtesy but largely from lack of ability, had I the desire. I know he will not take any exceptions to what I have to say, for we are of one mind in the matter.

In the first place, we can, for all practical purposes, divide all morbid conditions into two groups, acute and chronic. The former needs prompt and immediate attention, and we should at all times be prepared to make a good prescription. The latter give more leisure for a study of the phenomena and a search for the *similimum*. Now the work which we do in preparing for treatment of the acute case will serve, if nothing else, as a sort of training—mental training—for the work needed in the chronic one. So then our study of symptomatology must be confined to the remedies that have most to do with acute affections. The earlier workers in this field divided the remedies into groups on this basis, not into vegetable, mineral, and animal. The first of them, known as the *polychrests*, embraced

only such drugs as all practitioners had with them habitually, and varied in number from twenty to thirty. This might be the list, in this case about thirty-four :

Acon., apis, ars., bell., bry., calc. c., cham., chin., coloc., digit., dulc., euphr., gels., graph., hell., hepar., hyos., ign., ipec., kali b., lach., lycop., merc. corr., merc. v., nux v., phos., puls., rhus, sep., sil., sulph., tart. em., veratr. a., zinc.

Now, take one of these remedies and compare it with another that has some sort of similarity in pathogenesis, such as *acon.* compared with bell., gels., nux v., rhus, and, perhaps, veratr. ; compare them, paragraph by paragraph, underscoring with red the symptoms of *acon.* that are found under any of the others, adding the names of these remedies. All the unmarked symptoms, therefore, are pure aconite, as compared, at least, with the related drugs. Now, go over these, carefully, intelligently, and pick out all those that are unique, peculiar, and presumably characteristic—such are fear of death, restlessness, etc. These can be marked, say in blue, and will form the basis of study.

I am quite sure you will soon see that, the so-called “conditions” and “generalities” will stand out as the peculiarly characteristics, more especially the aggravations and ameliorations. In fact, in my own practice, these take rank of the first order. Fix these in mind ; recite them to yourself and others, until they become part of yourself. Now, go to the next related remedy ; treat it in the same manner ; and the task will grow easier as you proceed, the mastering of one drug will go far towards comprehending the next. After you have gone through your polychrests, and during your study, of course mark every verified symptom—every symptom that you have observed in your patient, and that has disappeared under the action of the remedy. These verifications you can mark with a dot, cross, or what not ; and by and by, you will be pleased to find that every case you have cured with aconite has had certain symptoms inevitably present. This will do two things for you : First, it will indicate to you the central and essential symptoms in the drug, and shorten your work in similar cases in the future ; and, second, it will be a memorizer, fixing the action of the drug in the mind. It is a very comfortable fact, that when we have once *done* something with a remedy it remains in our memory.

When you leave school, let me urgently advise you to arrange systematic reading. Have certain subjects that you lay out to read regularly in time of leisure. But, in addition, set apart one hour

in every day, one that is likely to be uninterrupted, for materia medica study ; you may put it down as a fact—a fact about which there can be no dispute whatever—that no matter what your skill may be as a diagnostician, ability as a surgeon, or attainments in science, the one thing that will give you reputation, and also, of course, bring practice and professional success, will be your *results*, and these results are in direct relation to your knowledge of materia medica, and ability to apply this knowledge promptly in all emergencies.

A systematic study of the few drugs daily in use in acute practice, while pure drudgery at first, does more than might at first sight appear. It trains the mind, not only as to habits of study, but in apprehension in that particular department of work. Other drugs are more readily mastered, and the faculty, so essential in a good prescriber, to quickly detect a central symptom, or group of symptoms, is quickened and cultivated. You will often see first-class prescribers reach the proper remedy after what seems a very cursory examination of a case, while others, equally as good, will be able to reach the same conclusion only after a laborious examination and weighing every symptom no matter how minute.

Another point, of much value, I think, notwithstanding the objection many first-class practitioners make to it, is the association of a group of remedies with certain morbid conditions, as facilitating the selection of the remedy—as vomiting, as suggesting ipec., ars., iris v., tabac., nux v., phos., etc. Of course, we do not prescribe for pathological states by name ; but, as such states are known and recognized by a definite group of symptoms, there must be an invariable association with certain remedies. Hence, I always attach much importance to correct diagnosis, that is, by exclusion—as the diagnosis and selection of a remedy goes on together. Suppose, for illustration, a learned zoologist wishes to announce that an animal of yours is in difficulties, and commencing with the head, goes through a scientific description, giving account of hair, etc., you might never know what it was. But if he told you he had seen your cat, dog, or horse in difficulties, you would get definite information. In acute practice, if a patient had sudden colic ; sharp, cutting pains ; bending double for relief, and so on ; you would see *colocynth* in it at once, and would have no interest whatever in the host of associated symptoms. It seems to me, and if my experience is worth anything, it cannot be doubted, that the proper way to study materia medica for *practical* purposes, is in some such way as I have indicated. If you do it as faithfully as I have done, you will some day have a handy

book, like my copy of Lippe's *Materia Medica*, marked all over with many-colored hieroglyphics, but full of just such verifications that have become rooted in your memory.

Now, in chronic practice, there must be some modification of this plan of work. Often and often, the remedy may be a polychrest, and you will have no trouble to find it. But again, very often, the true similimum will be a rarely used drug, one that, perhaps, you will not use more than once or twice in a lifetime. Here is one difficulty. In old chronic cases, the long suffering or confinement gives rise to a host of fictitious symptoms.

The patient becomes hypochondriacal or hysterical. Not only do they *imagine* symptoms, but these will-o-the-wisps are the most obtrusive; they give the patient the most concern, and they insist upon them most vigorously. Now comes in the value of scientific training, in the ability thus furnished to hunt up obscure objectivities, and thus enabling you to exclude all these subjectivities that are not verified. Having hunted down your veritable symptoms and selected the central controlling ones, the task of finding the appropriate remedy must be essayed—you can rarely do this with only the symptomatology to guide you; you must have a good repertory—Gentry's *Concordance* is the most voluminous, and, I suppose, the best one to get. But I have worked so long with my little Boenninghausen, that I rarely need any other. The *best* repertory, after all, is very much a question of experience; as Prof. Meigs used to say about obstetric forceps. "The best is the one you have used the most." A repertory you must have; perhaps one is as good as another when you get accustomed to it. The ability to use a repertory to advantage depends upon the ability to get the key symptoms in the case. If an unimportant symptom is selected, the remedy may never be found. Now by "important" and "central" I do not mean one that is unusual, striking or prominent; it *may* be all that, but must be something more. It must be the symptom that governs the case. Oftener than otherwise it will be a notable and unvarying aggravation, sometimes an amelioration. As a case in point, I have cured so many cases of facial neuralgia with lycopodium, where the right side is affected, when they are worse from 4 to 8 P.M., and better in the open air, that I cannot believe any such case can possibly be cured with any other drug. Now *all* these symptoms are essential, a left-sided neuralgia will not be cured by lycopodium. Sometimes "side" does not come in. For instance, I have a prompt cure of supra-orbital neuralgia, either right or left, if the pain is mitigated by hard pressure, and the tendency is to ex-

tend backwards over the head. Now just what the central symptom will be in any case cannot be predicted; it needs careful search and education to detect it, and often the searcher will fail. If he never failed, and had a good repertory to point him to the remedy, I honestly believe all diseases would be curable.

With reference to these central symptoms, again, we must learn to interpret them in another way. The language of the original provers is nearly always retained in our symptomatologies, and occasionally we find certain words capable of two meanings. For instance, once I hunted Boenninghausen through for "worse from having the hair cut," having a patient who always had headache and coryza after a visit to his barber. I was reproached by a first-class prescriber to whom I went in my trouble for inability to read between the lines. I told him it was not in Boenninghausen, when he opened the book at "worse from having the head uncovered," and stating "what do you call that!" Well, I called it *belladonna*, and got a lesson, also, that I still remember. I think when we fail to find what we want in a repertory, it is oftener than otherwise because we have a form of expression in our minds, and do not recognize the same thing when differently stated.

One more point, and I am done. There are certain symptoms, or rather *conditions*, involving extensive tissue changes, that have never been brought out in a formal proving, and yet they have disappeared so promptly under the action of a remedy given for associated and purely pathogenetic symptoms, that they have gradually become incorporated, and are known as "clinical" symptoms. It seems to me that if the time ever comes when our knowledge of drug-action is as accurate and minute as I have described earlier, we can see these extensive tissue-changes foretold and promised in the development of the case. The verification of such symptoms, as the absorption of scar tissue, and many others—must be one of our cares. Those that we have must be studied with reference to the precedent phenomena, and carefully kept in their present relation to the *pure* pathogenesis. They sustain the relation of cause and effect, but in the present state of knowledge cannot be as dogmatically stated as we may hope for in the future.

But I have said enough to give you hope, I trust, for the future of a scientific therapeutics, and courage to do your part in hastening realization. When this work is done, and the roll of the names of the workers is made up, let us all find our names thereon, and the Homœopathic Medical Department of Iowa's University, and more particularly its *Hahnemannian Society*, not at the foot of the list.

WITHOUT THE KNIFE.

BY WALLACE MCGEORGE, M.D., WOODBURY, N. J.

(Read before the West Jersey Homœopathic Medical Society, February 15, 1893.)

FOR years there has been a tendency among physicians to unnecessarily use the knife, and neglect to use medicines in the treatment of glandular enlargements and abnormal growths. It may be popular, it certainly is profitable to operate, but is it proper, is it humane to extirpate when the trouble may be removed by absorption or resolution, assisted by skillful medication?

That there are cases where the knife is necessary and where by its skillful use lives have been saved, I freely admit, but is there not a reckless haste in advising or consenting to surgical interference, before the proper remedy has been administered? I have known cases where patients have been operated on because the doctor was too indolent or too ignorant to search out the similimum, a doubting Thomas, with little faith in the virtue of his remedies. As a remarkable instance of the power of nature with well directed treatment to overcome and absorb, I cite the following case.

On January 26, 1887, in Woodbury, a little girl was born apparently sound and well formed. On the second day after birth her grandmother, who was temporarily acting as nurse, noticed a hard substance under the skin of the right thigh. She describes it as resembling a piece of white gristle. The doctor's attention was called to it, and he says it was about as big as an almond when he saw it on the third day. It increased rapidly in size, until on the eleventh day he decided to introduce a needle and apply electricity on his succeeding visit. But on that day the doctor's horse got frightened at the cars and ran the carriage into a hole, the doctor was thrown out and so seriously injured that for nearly five months he was unable to resume his visits. When the babe was three weeks old two eminent surgeons were summoned from Philadelphia to examine and decide on what should be done. By that time the tumor covered one-half the distance between the knee and thigh. After a careful examination and consultation they recommended that no later than the following day, they would advise that amputation at the hip-joint be performed. But the child's parents and grandmother objected, and declined to consent, and no surgical treatment was undertaken. Later a celebrated electrician from Philadelphia was consulted, but

he advised against the use of electricity. The tumor continued to grow until when I was shown the case in May, it was nearly as large as the child's head and as hard as bone. As the child was otherwise healthy and well developed, I advised the mother not to consent to an operation (not knowing at that time that they had positively refused months ago to consent to amputation).

Nothing was done to promote absorption until she was five months old, when the family physician, Dr. H. C. Clark, a skillful old-school physician, had recovered sufficiently to get around among his patients again. He then began a systematic treatment of the case, and exhibited one drop of the fluid extract of arbor vitæ (Americana) in water three times a day, and had the same medicine applied externally to the tumor. When he began his treatment the tumor extended from the knee to the groin, and was as hard as bone. It had been diagnosed again and again as osteo-sarcoma, but Dr. Clark did say it was a bone cancer. This treatment was persevered in faithfully, the dose eventually being increased to two drops instead of one. In six months' time it had entirely disappeared; a very gratifying result to the child's relatives; and a very creditable one for Dr. Clark.

When I examined this little girl on February 11, 1893, I could see no trace of the tumor, no scar nor cicatrice, only a little depression in the lower third of the internal part of the thigh. The history of the case I learned from the child's grandmother, a very intelligent lady, and the name of the medicine from the family physician. And this treatment, by medicine, was by a physician who has the reputation of being the most skillful surgeon in the county, one who not only knows how to use the knife, but who also knows how to use the proper remedy.

The following cases in my own practice, although not so interesting in many particulars as the one given above, are instructive as showing the power of the properly selected remedy to dispel or remove abnormal growths without resorting to surgical interference. In June, 1868, I was called to see a lady who fourteen years before had had the outer half of the right mamma and axillary gland extirpated, to remove a cancer. I found her suffering with a lump in the inner half of the same breast, as large as a hickory-nut. On account of the burning pains and her great anxiety, I prescribed *arsenicum* 2c, under which remedy the lump became smaller, the greatest improvement being noticed in October, after which time I did not see her until the following summer, when she returned,

complaining that her breast troubled her very much. As the pains now were burning and darting, and there was very little of the anxiety she manifested the previous year, *carbo animalis* 2c was administered. The improvement was gradual, and in November there was very little swelling left and an entire absence of pain. I gave her some more medicine and she did not return. In the following spring I moved from Hightstown and lost sight of the case, and cannot give the ultimate result, although I met her looking well several years after.

On November 25, 1891, I was called to see Mrs. H., æt. 47, a thin, spare lady, suffering with a lump in the left breast. She had been referred to me by Dr. Raue. Examination showed a lump or tumor as large as an English walnut but not round on all sides, on the inner side of the left mamma. From the history of the case, dating back to a bruise received some years ago, I gave her *conium* 30, a dose every four hours for three days, then a dose only twice a day. Next month she had an attack of la grippe, and when she recovered from that I returned to *conium*. I saw her occasionally, but did not notice much improvement for six weeks, when I observed that it was softer to the touch. In another month it was smaller and softer. Next month it troubled her very little, but instead she complained of a lump in her right breast. This worried me, and after some study I concluded to give her *carbo animalis*. For some time there was little change except that her general health improved, and I advised her to make a visit to friends in Washington and Virginia, and only to take an occasional dose of the medicine. On July 12, 1892, I prescribed for her again, repeating the remedy, since which time she has taken no other medicine for this trouble. I have heard several times since of her continued improvement, but being anxious to see as well as to hear, on January 23, 1893, I called and examined the case. She was looking well, much stouter, and apart from the fact that her hair was grayer, she was younger looking than when I first saw her in 1891. But best of all, in neither breast could I discover any trace of any enlargement nor any hardness, but I did see and feel a normal mammary gland. From her own lips I learned that the treatment of her case had been satisfactory, and all the members of her family were grateful for what had been accomplished by medicines in removing this shadow from their home.

Did time permit, other cases might be given, but these three will show what may be accomplished by the faithful, persistent applica-

tion of the proper remedy in the crude drugs as well as in the potencies. I had intended to say something about the treatment of goitres by medication, but for the same reason will defer this matter till another time. May not the mention of these cases incite some brave operator to hesitate before destroying by the knife that which never can be restored. While it is skillful and daring to amputate or extirpate, it is glorious and humane to make whole those committed to his care. Remember Hahnemann's admonition—"The first and sole duty of the physician is to restore health to the sick. This is the true art of healing."

SECALE CORNUTUM IN COLLAPSE.

BY T. C. IMES, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

IN view of the possible occurrence of cholera in this country during the coming year, and also in view of the past and present prevalence of congestive diseases west, south, and elsewhere, the subject of collapse becomes of commanding importance. Among the remedies most deserving of study in this connection, and perhaps one of the least understood, is "*secale cornutum*."

A case occurring in my practice during the present year, in which this drug proved effective, is here offered as a contribution to this inquiry.

Mrs. T., æt. 24 years, married, two children. May 30, 1892, about two o'clock in the morning, was taken violently ill with vomiting and purging. Common household remedies were used, but without relief, the attack continuing until late in the afternoon, when I was summoned. The patient was found to be greatly weakened by the frequent discharges. Temperature, 98°; pulse, 70, and very weak. There was profuse cold sweat on the hands and face, and violent thirst for cold drinks, taking large quantities, and often repeated. *Veratrum album* 8x was prescribed, which gave prompt relief. This improvement continued for several days, small quantities of beef broth taken as nourishment, the temperature remained normal, and all things bid fair for a speedy recovery.

June 4th, five days after first attack, a slight chilliness was observed in the afternoon, which at first was not regarded as being of

much import, but which gradually increased, and with it a return of the nausea, vomiting, and purging. So rapid and violent was the action that within two hours from the onset she was given up by the family as being dead. Indeed, my own first impression at this visit was that the case was hopeless, the appearance being more that of a corpse than a living body; the cold sweat was so profuse as to completely saturate her clothes and bedding. The temperature taken under the tongue (after learning that no cold drinks had been recently taken), registered 96.4; the pulse was almost imperceptible. Notwithstanding this condition, with what little strength remained she made signs expressing a desire to be fanned, but "gently" (china). There was not enough strength to whisper. Recognizing the nature of the case at a glance, there was no time nor need to sit down and study symptoms, and what was done must be done quickly. The choice fell upon *secale cornutum*, which was prescribed in the 6x, a dose to be given every five minutes until six doses were taken; meantime medical counsel was sought, and as often in cases of emergency, none of those desired were to be found at home. Returning to the bedside, the application of heat already begun was continued, with brisk chafing of the hands and feet; the medicine, after the first half hour, was given at longer intervals. After an hour's treatment she was recovered sufficiently to take a small quantity of beef broth and retain it on the stomach. She was also able to speak in a whisper. *Secale* continued, with half hour to intervals of one hour. The application of heat was continued, although she used every effort to resist it. At the expiration of the second hour the pulse was greatly increased in strength, but only slight change in temperature. It was now observed that the secretion of urine was totally suppressed. At 12.30, midnight, she had so far recovered that all her clothing was changed, dry sheets placed on the bed, and she expressed herself as "feeling much better." The temperature had risen to 98°, there was thirst for cold water in large quantities, which was allowed her. *Rx. Secale* every two hours.

June 5th.—At 8 A.M. another and more sudden change took place, death again seeming imminent. The temperature had fallen to 97.8°; the pulse, as near as could be counted, 132, and very feeble; skin, cold and clammy at first, was soon bathed in cold sweat. Arriving at the bedside at 9 A.M., the dosage, which had been lengthened to two hours, was repeated with former frequency, and Dr. John C. Morgan called in consultation. After a careful examination, it was agreed to continue the remedy already given, raising the potency to

the 12x. For fully a half hour there were few signs of life save a trismic action of the facial muscles. At the expiration of an hour there was marked vital reaction, the patient taking several teaspoonfuls of beef broth with a trifle of salt. *Rx.* Secale every half hour.

June 6th.—The temperature had reached 99°, the pulse 120, becoming more even and stronger. A scanty flow of urine, and no vomiting or purging had occurred during the past 24 hours. *Rx.* repeated.

June 7th.—Temperature 98.8, pulse 120, resting quietly, feeling stronger. Had a slight attack of nausea early in the morning, with several thin, watery stools. This was followed later in the morning with three stools in rapid succession; this being regarded as a slight aggravation of the drug, the intervals were extended to *two hours*.

June 9th.—Temperature 98.8 and pulse 120, the same as on previous day, but with improvement in fulness and strength of the latter; the skin still cold; stomach and abdomen very much bloated; about 11 A.M. involuntary stool and urine, both being passed together. Fearing that some obscure disturbance might be lurking in the system, council was again held, when it was suggested that the conditions might be due to a further aggravation of the drug. They were especially observed at 2 A.M.; nausea, but no vomiting, with a desire to stool, or a small stool. *Rx.* Sac. lac.

June 11th.—Temperature 99.6, pulse 120. The temperature being increased nearly 1°, the use of sac. lac. was justified by the evidences of reaction now seen. Flatulence abating, the swelling reduced in a remarkable degree. Little discomfort, thirst lessened. *Rx.* continued.

For the following five days the patient was in a partial stupor, a typhoid lethargy, the temperature rising at times as high as 102.4, with aggravations at 4 P.M. While in this state, two doses of china 200 were given, but without any apparent results. It had been observed for several days that there was a "flapping of the alæ nasi, with a grunting respiration; these symptoms, with the 4 P.M. aggravation, the typhoid state and the flatulence" led to the choice of lycopodium 200, a dose every two hours, two doses only being given, this to be followed by sac. lac. Improvement again set in and we were once more hopeful. *Rx.* Sac. lac.

June 20th.—In the early morning a light return of tympanites was noticed, and with it a deep-seated sore pain extending down to the loins; worse on the left side, the pain increasing with the advance of the morning, accompanied with strong bearing down.

Temperature 99.8, pulse 102. This "sore pain" and "bearing down" had been present at different times since her last confinement, nine months previous, at which time she thought proper attention had not been given, the accouchment taking place while in the country.

Two doses of *mercurius vivus* 200, with an interval of four hours, was prescribed.

June 21st.—Temperature 99.8; pulse 100; stronger; pain and soreness nearly gone; takes beef-broth as nourishment, with grape juice for thirst. *R. Sac. lac.*

June 22d.—Temperature 99.8, pulse 100, pain and soreness entirely gone, also the abdominal distension. From this time forward there was gradual improvement, save that the temperature remained slightly elevated; this was regarded as the post-febrile condition of convalescence discussed in Wagner's *Pathology*, p. 623. The appetite improved, food being taken with relish, and the functions of the body returning to normal.

On the 23d of July she was taken to the country, from whence occasional reports stated a return of good health. She has since remained in good condition.

A STUDY OF THE MAGNESIUM SALTS.

BY SAMUEL C. WEBSTER, M.D., MEDIA, PA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

It has been said by an eminently wise authority that "there is no new thing under the sun." Perhaps one is most forcibly impressed with the truthfulness of this trite saying when he endeavors to prepare a paper on *materia medica*. However, truth is always truth, and no matter how often it is rehearsed, it never changes. Indeed, it is the continual going over and over, and over again, which makes us familiar with those things with which we wish to become acquainted. Knowledge and accuracy of matters have to be studied alone, or obtained by repeatedly going over them. Perhaps, there is no sphere in which man can be placed which verifies this truth more than that of a homœopathic physician. Our battle-axe is our *Materia Medica*, our enemy is disease, and just as surely as we are thoroughly equipped with a full knowledge of our *materia medica*,

and an ability to properly interpret morbid symptoms, just so surely will we come out victors in the field, and the dread maladies of human flesh will vanish before our eyes. Our failures will largely depend upon our ignorance of *the* remedy which is destined to be the similimum, and the reason of this ignorance is largely due to the fact that we have not studied that particular similimum sufficiently to be acquainted with it.

Thus it is, that I am obliged to ask your indulgence with me whilst I speak somewhat shortly upon some of the salts of magnesium. These are all definite chemical compounds, formed by the union of the element magnesium with some acid radical; a few compounds of magnesium with other elements exist which are not, truly speaking, salts of magnesium, the most common of which, as it commercially exists, is the ordinary "magnesia" of the shops; this is an oxide, but is artificially manufactured from one of the salts of magnesium, namely, the carbonate.

Magnesium (which gets its name from the town Magnesia, in Asia Minor, where "the native carbonate of magnesia" was first discovered) is a lustrous metal as white as tin; its symbol is Mg, and its atomic weight 24. It does not tarnish in dry air, though in damp air it soon becomes covered with a film of mag. hydrate. Cold water acts but slightly upon it; hot water more so. All acids dissolve it, with the evolution of H. It melts at a low red heat, and volatilizes at higher temperatures. When heated in air to a high temperature it takes fire, and burns with a bluish white light with great brilliancy and with high actinic power. It is usually seen, commercially, in the form of narrow ribbon. The salts of magnesium, however, are not obtained from the pure Mg, but generally from natural compounds. The greater part of all the magnesium and its salts are obtained from mountain or magnesian limestone or dolomite, a double carbonate of magnesium and lime. Magnesite, a tolerably pure carbonate, and kieserit, a monohydrous sulphate, occurring in Prussia, are also sources of Mg and its salts. Other natural compounds exist.

Dolomite is a hard, stony material, abundant particularly in England. It is there used for building purposes. The House of Parliament, the School of Mines, in London, York Minster, and Westminster Hall, are all built of it.

From a medical standpoint, the carbonate, the muriate or chloride, the phosphate and the sulphate, are the salts which have claimed the most attention, particularly from the homœopaths.

The oxide and the solution of the citrate are, perhaps, the more

commonly used in the old school. The sulphate, or epsom salt, is also a favorite remedy with them; this is one of the more potent cathartics, so much so that it even has a wide field of use in veterinary practice, side by side with sulphate of soda or Glauber salts.

The physiological or pathogenetic action of this group of remedies is not very varied. The grand and most important point of disturbance is in the alimentary canal; yet, by careful and systematic provings, it is found out that many parts of the body become impressed by their action. The therapeutic use given to them by the old school is scarcely more than that of giving a dose of "salts," a decidedly scientific measure among them—the old school.

Now, from a really scientific, therapeutic application of these drugs, which is according to the law of similars, let us consider some of their important uses.

The grand rubric for them all is the gastro-intestinal tract; some slight difference of action is here noticeable. Commencing with the carbonate in this sphere we have stool—green, watery, frothy, with green scum like that of a frog pond, while masses like lumps of tallow floating in the green, watery stools; bloody mucus, greenish-yellow, slimy mucus; profuse, sour-smelling stools; cutting and pinching in the abdomen before stool, with rumbling and emission of flatus. Tenesmus occurs during and after stool. Sourness seems to be an accompaniment of mag. carb., which is important to note. Sourness of the whole body.

Bell, in his *Therapeutics on Diarrhœa*, says: "Much of the ground which should have been occupied by mag. carb. has heretofore been given to coloc. and mercurius; a better acquaintance with the former will prevent this in the future. It is a remedy of the first order in dysentery and infantile diarrhœa. The stools are highly characteristic. The bloody mucus is found mixed with the green, watery stool, sinking to the bottom of the vessel and adhering there, but the watery stool occurs alone."

In comparing this remedy with a few of its close allies, we are led to differentiate by the following symptoms:

Colocynth has green, slimy stools instead of green, watery ones, whilst the colicky pains and so forth are decidedly similar.

Mercurius has a very much greater amount of tenesmus, with frequently bloody stool.

Rheum. The similarity here is great, mag. carb., however, being a deeper acting remedy. With rheum we have sour, slimy, frothy stools, with griping colic and twitching of the muscles of the face and

fingers during sleep. Farrington says that *rheum* should precede *mag. carb.* if there appears any doubt as to which is the right remedy. He also says that *rheum* is rather a treacherous remedy.

Chamomilla has a distinguishing stool in that it is yellowish-green looking, like chopped eggs, whilst many of the other symptoms coincide.

Calc. ostrearum has sweat on the head, face and scalp; damp, cold feet and enlargement of the abdomen, etc.

These grand characteristic symptoms of *mag. carb.* in reference to the gastro-intestinal tract are particularly referable to those disturbances associated with dentition in young children. When the remedy becomes useful in adult life in this rubric we have the stomach and liver symptoms to predominate, presenting a fairly good picture of "acid dyspepsia."

The gastro-intestinal symptoms of *magnes. mur.* are more those of constipation; we have a hard, difficult, slow and insufficient evacuation. The stools are knotty and usually formed into hard balls, resembling sheep's dung. These stools crumble at the verge of the anus. Opium and *magnes. mur.* closely resemble each other in the stool. Aside from other differentiating symptoms, the opium stool probably does not crumble so much.

With *magnes. phos.* in the gastro-intestinal tract we have for the leading indication *pain*. Enteralgia. Flatulent colic forcing the patient to bend double; flatulent colic of children; spasmodic conditions of the intestines; watery diarrhoea, with cramps, so severe as to simulate those of cholera. This is pre-eminently a remedy for *pain* in this rubric.

The mucous membranes of the female generative organs are also impressed by this group of remedies, causing irritation and catarrhal inflammation, deranged menstruation, etc.

Here with the carbonate we have menses too late and scanty. The menstrual discharge is glutinous, thick, acrid, black and pitch-like; but *the* peculiar indication in this rubric for the carbonate is that the flow is more profuse during the night than during the day.

Now, with the muriate we have menses too early and too copious; with this remedy hysterical manifestations are more common, whilst with the *phos.* the predominating symptom is *pain*, menstrual colic, ovarian neuralgia, particularly on the right side.

Schüssler, who has so ably supported his theory of the tissue remedies, says of *magnes. phos.* that its general action is upon diseases having their seat in the nerve-fibre cells, or in the terminal bulbs of

the nerves, in the muscles, or in the muscular tissue. The pains are darting, spasmodic in character, boring, lightning-like, accompanied by a constrictive feeling; they are often changing in locality, and are relieved by warmth and pressure. It is purely anti-spasmodic, its application being in cramps, spasm of the glottis, tetanus, epilepsy, spasmodic retention of the urine, paralysis agitans, etc.

The half has not yet been told of the usefulness of this little group of remedies, and the writer feels that his intention of setting forth in a clear manner the indications for their use has not been arrived at; therefore, before spending our precious time in looking up the unnumbered host of new and fancy remedies, let us study thoroughly the magnesium salts. Our honest efforts will be well rewarded.

ACCIDENTAL PROVING AND CLINICAL EXPERIENCE WITH GRANATUM CORTEX.

BY. T. HART SMITH, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

IN 1866 I was called to see the child of Mrs. G. The mother informed me that her child was suffering, as she supposed, from worms, it having the peculiar symptoms that the laity are usually in the habit of attributing to that cause. After prescribing the ordinary remedies without avail, at the suggestion of a druggist I procured an ounce of the tincture of the bark of pomegranate root and gave it to the child, fifteen drops three times a day on an empty stomach. The first day there was no evidence of any ill-effect, but at noon on the second day I was hastily summoned to see the child and found it suffering, as the mother stated, with suffocating attacks. The child in running across the room would lose its breath and fall unconscious. From her statement I gave the child moschus, not attributing the condition to the above prescribed remedy. After an interval of two or three days I determined to return to the granatum, and on the second day, or after the fifth dose of the remedy, the child was again thrown into this spasmodic condition, but with more alarming symptoms than before. The parents accusing me of having poisoned their child, and no improvement setting in, I sent for Dr. P. S. Hitchens, and after a reasonable time by the application of several remedies, we were able to quiet the child, and through his influence, the family gave me no further annoyance.

Doctor Hitchens, being an old practitioner and a more careful observer, congratulated me upon having discovered what might prove to be a valuable remedy, as he informed me at that time he had never known or heard of any drug that would produce spasms of the glottis. He also advised that we should test the remedy in any future cases we might be called upon to treat. Shortly after this Dr. Hitchens was called to see a child of an irritable and excitable disposition, who upon being crossed or in any way vexed, would throw down whatever object it had and run across the floor and fall into a state of asphyxia. As he told me afterwards, the picture of Mrs. G.'s child was present and he immediately sent and procured the granatum and the relief was almost instantaneous. The family informed him that this had been the habit of the child for several months. The remedy was continued at interrupted intervals for several weeks, without any recurrence, to my knowledge of the paroxysms. Shortly after this I was called to see Miss A., a nervous, hysterical creature. The family informed me that she had been so since the first appearance of her menses, and with every menstrual attack she would have congestion with nervous spasms and constriction of the throat, in which she would lose her breath, become purple in the face, and only by dashing water over her were they able to relieve her. The symptoms, and my anxiety to test the remedy, induced me to prescribe granatum in this case, and I am happy to state with remarkable results. Not only relieving the glottis but establishing the regularity of her menses, and relieving her of an annoying itching that she complained of at the anus. This induced me to investigate the case more closely, and, after consultation, I was permitted to examine the parts with this object in view, to see whether this irritation could be attributed to hæmorrhoids, fissure or if occasioned by the pests with which so many young persons are annoyed, seat or thread worms. Upon inspection of the anus I found evidence of the thread worm. In order to test the drug in this condition, I prepared the granatum that it might be applied to the parts night and morning; one-third granatum and two-thirds water, and continued granatum the second dilution internally. This treatment was effective in destroying all irritations at the anus, and for months there was no complaint from that cause. This induced me to try the drug with younger children and in the majority of cases the relief afforded, whilst not always permanent, has been satisfactory.

In whooping-cough with spasms of the glottis, I have yet to see

the case where the spasmodic condition is not promptly and permanently relieved. In the case of my own child, with which many of you are familiar, the paroxysms, perhaps, were the worst I have ever had the opportunity to observe. At ten days old the first paroxysm manifested itself; it was light. After the second day they grew rapidly worse until finally we despaired of her recovery, but by the continued administration of this remedy the attacks gradually lessened and she was restored to health.

In asthma, with the characteristic constriction of the glottis, I have found the drug to afford relief. It is possible for me to cite numerous cases to establish your faith in the efficacy of this remedy in the treatment and relief of spasms of the glottis. I however, desire and invite the co-operation of the physicians present to further prove the efficacy of this remedy. In order to do this I particularly request that the members of the profession present will accept of a small vial of the drug and test it in their practice and kindly report to the Secretary of this Society the results. Not that I have any doubts as to the efficacy of this remedy, but think it would be better to present it to the medical profession with such corroborations.

PROPHYLACTIC AND HYGIENIC TREATMENT OF TUBERCULOSIS.

BY C. S. COOPER, M.D., SYRACUSE, N. Y.

(Read before the Onondago County, N. Y., Medical Society.)

THE subject of this paper has a scope sufficient to occupy the thought and attention of this entire meeting, and then leave it only at the threshold. It opens up a vast field for research, requiring a minute care for every case. It calls for a thorough knowledge of the patient's surroundings; the mental and physical condition as well as habits of life. All must be passed in review by him who would attempt to cope with such a powerful antagonist.

It is not enough to simply prescribe according to the best of our judgment and go on our way, thinking it an incurable disease, leaving the patients to do as they please, feeling in our hearts that the only thing to be done is to make their last days as comfortable as possible, or send them on a trip to some celebrated health resort on

the foothills of the Rocky Mountains, provided they have means sufficient to take them there, and if not, breathe out a few months of existence among their old surroundings and the loved ones who are constantly pained by the wasting away of the once strong and vigorous body.

Tuberculosis is an infective disease, caused by a specific micro-organism which gains access to the body either through the skin or mucous membrane, and is found in abundance in giant and epithelial cells which form what is known as a tubercle. This little germ is universally considered to be the cause of the disease, as it never occurs without it. Families of a scrofulous taint seem especially susceptible to its effects.

Anything that tends to lower the vitality of the tissues, such as uncleanness, bad food, exposure to cold and wet, heart troubles, asthma, etc., act as predisposing causes. Dwellers of the temperate zone are more susceptible to the disease than those of a colder or warmer climate, probably because of the more frequent and extreme changes in the temperature. Age also seems to have an influence, as the greater number of cases occur before thirty. Under ten and in old age it is rare. The colored race and Indians suffer more than the whites. Any organ of the body may be attacked, but those of special functional activity are the ones usually affected. The mucous membranes everywhere are liable to an attack. Serous sacs, synovial membranes of joints and the bones of children are especially favorite points of selection. Whenever there is an injury like a cut or bruise, breaking the skin, an inflammation or strain of the joints, the bacilli are liable to gain a foothold, the weakened tissues giving them a better prospect for life and development. In these local lesions the bacilli are usually held for a time without further infection, for instance, the glands of the neck, which if removed early, there is no danger of a systemic trouble, but when they get into the blood-current the infection is rapid. A tubercle is a grayish white, translucent semi-solid granulation made up of lymphoid and giant cells, and is subject to caseous or fibroid degeneration. The caseous form being the most common, softens, breaks down and forms ulcers, leaving large cavities in the lung, or if in subcutaneous tissues, long sinuses are apt to form.

In all the tissues of the organism a power, to a greater or less extent arresting the development of disease-producing germs is present, and if for some reason the normal resistance has been reduced in its power to cope with its antagonist, the latter, as it were, crowding back, step

by step, the vital forces which have hitherto predominated, stealthily creeps into new positions until the whole structure has become its impregnable fortress. Thus far every effort to destroy the bacillus has been unavailing, and though scientists have racked their brains no specific has been found.

The bacilli are not thrown off in the exhalations of the patient, but the sputa contains them in enormous quantity. They cannot escape from a fluid media, but in a dry state they become pulverized atoms and float about, thus becoming a common source of infection.

The stools, where the intestines are affected; tuberculous ulcers; glands and bones, are all sources of infection, as well as milk and meat of tuberculous cows.

Dr. T. Mitchel Pruden in 1891 estimated the number of bacilli in the daily sputum of a single patient at 21,460,000. It has also been shown that the sputum dried and preserved under conditions usually found in ordinary dwelling-houses, to retain its virulence for a long period.

In the *American Journal of the Medical Sciences* for March, 1891, one experimenter claims it has lasted for a period of over three years. At the present time there is no satisfactory data in regard to the length of time necessary to destroy the vitality of the germ.

Numerous cases are reported in the journals of direct communication of this dread disease, to say nothing of those which have fallen under our own observation.

The *New York Medical Journal*, of May 21, 1892, reports the case of a healthy girl of fourteen years, infected by wearing the earrings of a consumptive.

Ten Jewish boys were circumcised by the same rabbi, who was a consumptive, and all were infected, seven dying, the other three developing tuberculous glands. Numerous cases have been reported where people have been infected while caring for patients through cuts or scratches on the hands; in fact, any abrasion of the skin or mucous membrane of the mouth or nose where the bacilli might lodge before reaching the lung tissue of one susceptible of inoculation, is almost equally as destructive; for this reason all operations upon bones, glandular swellings and tuberculous joints, should be done with the utmost care, and with the strictest aseptic or antiseptic precautions. This communicability of tuberculosis shows the necessity of a rigid prophylaxis. But how is this enemy to be destroyed? Recent investigations have shown that such disinfectants as carbolic acid, potassia, sulphate of copper and chloride of zinc are

useless, that even a 10 per cent. solution of carbolic acid made no change on the sputa in twenty-four hours. Corrosive sublimate is equally useless through the coagulability of the albuminoids. Creolin seems to have no effect whatever, though a 10 per cent. solution of lisol, is the only one of all that proved its ability to destroy the germ in twelve hours. In surgical operations, iodoform stands pre-eminent though I have never seen a report of its disinfecting power. Probably it is used for its drying and stimulating properties as Moulin says that "it is by no means certain that it is a germicide." The experiments by heat have been very satisfactory as it destroys the life of the germs at 80° centigrade, or 175° Fahrenheit. No person suffering from phthisis if they have any regard for the health of their friends, the prolongation of life and the welfare of mankind in general, should ever allow themselves for a single time to spit upon the ground. They should rigidly adhere to the following rules for their own benefit as well as that of others.

When indoors to either use a paper cup which can be burned every night with its contents, or a spittoon which can be sterilized every night by putting it into some suitable receptacle and heating it to the boiling point. If walking about a cloth should be used, carried in a rubber receptacle and burned on their return. Rinsing of the cups is not sufficient, besides it is dangerous to the attendant. Nothing but the most thorough and persistent effort along this line will be at all successful in checking the progress of this increasing malady. Some time ago there was reported in a journal the case of a young ladies' seminary which had its milk supply from one cow; as time passed on one after another were stricken with consumption till quite a number of the pupils had been sent home to die, when it was discovered that the cow was diseased, and had been the cause of all the trouble. Boiling milk will destroy the germs and is the only safe way for those who use it.

The under-clothing of the patient should be of wool the year round and frequently changed. Women should avoid tight bands; and there should be an absolute freedom of muscular movement together with a free circulation throughout the body.

The living-room of the patient is to be well ventilated with an open grate if possible, no carpets or upholstered furniture, no pictures to hang or stand about to catch the dust. The bedstead should be of iron, with wire springs, hair mattress and wool blankets, nothing more. The floors and walls should frequently be wiped with a damp cloth to remove the dust or any particle of sputa which might

have been thrown off by violent coughing. Each patient should have a sleeping-room to themselves with plenty of fresh air, which should be admitted through an adjoining room. Sprigs of pine, fir or spruce, made into a pillow upon which the patient can recline or lie, is of advantage; they have an agreeable odor, and tend to allay bronchial irritation. The use of kerosene for heat or light is to be condemned; it consumes too much oxygen and the odor is offensive. The peripheral nerves are to be stimulated with electricity, friction, etc. The temperature of the living-room should be about 70° and the atmosphere on damp days is to be kept dry by means of a grate fire. The patient must be made to feel that he is going to recover, as fear has much to do with the health. Recreation should be in the line to inspire thought, so as to divert their attention from themselves as much as possible, care being taken to avoid fatigue.

Vocal exercises by developing the respiratory muscles, and by carrying an abundant supply of oxygen to the air-cells, help expand the lungs and stimulate them to an increased action.

There are a variety of gymnastic appliances, such as pulley-weights, for developing the chest, and, in fact, every muscle of the body.

The pneumatic cabinet is of great benefit in expanding the lungs, and can be combined with medicated vapors where there is bronchial irritation. Out-door exercise should be indulged in every day in the year when the weather will permit. There is a great necessity for the patient to breathe through the nose when going into the open air from a warm room, especially in cold weather.

All exercise should be governed by the strength, and amount of food the patient is able to assimilate daily; and, as the appetite increases, so should the exercise.

Daily bathing, for cleanliness, with the addition of borax or aqua ammonia, after which the patient may be thoroughly rubbed with a coarse towel; some recommend this rubbing to be followed by an anointing with fresh lard beaten to a creamy consistency and perfumed; or petrolatum, cocoa butter, cotton-seed or some other oil. At night, before retiring, rubbing the invalid quickly with a damp cloth, followed by a coarse towel, promotes sleep; there should be no mental excitement in the evening, either from reading or conversation. Sleep is a great restorer, and ten hours' good sleep out of the twenty-four is none too much for invalids to regain their wasted vigor. To promote sleep, the feet must be warm; if they are cold, they can be warmed by wrapping in flannel, with a hot-water bottle

or soap stone. The return of long periods of natural sleep shows that the patient is making progress towards recovery.

Feeding is a subject upon which there is a difference of opinion—what will do for one will not do for another. Dr. Asa F. Potter, who has treated about four thousand cases, would like to have his patients eat two or three pounds of meat a day, and drink, at least, three pints of water. He believes in drinking large quantities of water, or aromatic tea of some kind, during the eating of the food. Bread should be made with cream of tartar baking-powder, and afterward toasted before being eaten. It is encouraging when the patient can partake of large quantities of milk, fresh butter, and sweet cream. Infusions of malt, beef peptonoids, peptonized milk, are all good.

For thirst, milk and water, or a fresh infusion of malt, is better than either alone. The malt preparation makes a very refreshing drink, and ten or twelve ounces a day can be taken provided it pleases the palate of the patient. The use of cod-liver oil, with some, is liable to derange the stomach, a thing to be avoided, for, if the power of digestion and assimilation are poor, the chances for a rapid improvement are correspondingly poor.

Many of the above suggestions cannot be carried out in ordinary practice, especially among the poor. Every city should have a sanitarium for consumptives, where, with proper care, the greater portion would recover, the possibility of infecting the masses would be avoided, and thousands of lives would be spared to health and happiness.

SCROFULOUS OPHTHALMIA.

BY F. W. MESSERVÉ, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

It is my purpose to-night to unite under this name what are commonly considered two separate diseases, viz.: phlyctenular conjunctivitis and phlyctenular keratitis, and perhaps a still better name than any of them is conjunctivitis lymphatica. For while the disease attacks the cornea it is usually only that part which is the conjunctival prolongation over it, *e.g.*, the surface epithelium. I have chosen this subject because of its interest to the general practi-

tioner, as it is probably the most prevalent of all eye diseases, and because neglect or improper treatment may lead to quite serious results.

Scrofulous ophthalmia differs from nearly all other conjunctival diseases in that it is a focal affection, largely confined to the bulbar portion of the membrane. The ulceration, which is the principal lesion, may heal kindly in a few days, the disease giving the patient but slight annoyance outside of the inflamed appearance of the eye. On the other hand, this small ulcer, which may have originated on the cornea, or gradually worked its way from the conjunctiva to the cornea, may become a protracted, stubborn disease, remaining superficial or passing deeply into the parenchyma of the part, giving the patient great suffering and the doctor a good deal of worry and work before he succeeds in effecting a cure. And, even after the subsidence of the condition, we may have left a lasting evidence of the disease in the shape of an opaque cicatrix on the cornea, which if placed centrally, will prove detrimental to good vision, not only by obstructing the passage of rays of light, but aside from this, by the contraction due to cicatrization, we may have a considerable distortion of the surface of the cornea, and so cause it to become an irregular refracting surface, this condition giving rise to a chain of distressing symptoms.

SYMPTOMS.—The typical picture of so-called scrofulous ophthalmia is first a small, red eminence, or a number of them, varying in size from a pin-point elevation to a pustule nearly as large as a lentil, appearing about the junction of the conjunctiva and cornea, or somewhere within a comparatively narrow zone of the conjunctiva around the cornea, or upon the cornea itself. At first this eminence is conical, and is made up of a covering of surface epithelium, beneath which is an exudate. Soon the epithelium breaks down and we have a small ulcer formed which may heal kindly in from eight days to two weeks, or the ulceration may be protracted indefinitely. Again, at about the time of healing, or soon after, the same process may be repeated, and in this way we may, and do frequently have, attack after attack. At the time of the appearance of this eruption the surrounding conjunctiva becomes hyperæmic and the injected vessels radiate from all directions (except the corneal) to this minute nodule, or phlyctenule, in this way presenting a small, triangular hyperæmic area, the phlyctenule corresponding to the apex. When there are several phlyctenulæ, and this is usually the case, then by fusion of the triangles we will have a larger inflamed area, and out-

side of this, the conjunctival membrane may remain normal. The appearance of a phlyctenule upon the cornea is that of a small, gray nodule consisting of lymphoid cells between the epithelium and the tissue proper of the cornea. By the breaking down of this nodule we have an ulcer formed. The excavation is usually very shallow, as only the epithelium is affected. On the contrary the ulceration may penetrate deeply, even to the perforation of the corneal membrane; around the seat of the ulcer there is an infiltration which shows as a grayish or muddy haze. In the superficial variety ulceration soon ceases and healing sets in, the epithelium finally being reformed over the affected surface, leaving only a slight opacity which is readily absorbed. If the ulceration passes deeply we have newly-formed tissue following, which remains as a permanent, more or less dense opacity. It is this opacity which damages the vision. During the active stage of the disease we have generally abundant lachrymation, but as a rule, we do not have mucous or muco-purulent discharge.

SUBJECTIVE SYMPTOMS.—The most noticeable of these is the dread of light, the patient avoiding it as much as possible. Small children bury their faces in their mother's lap, or on her shoulder, or seek a dark corner of the room, even being willing to stay continually in a dark room. This photophobia is usually accompanied by a spasmodic closure of the lids, often rendering it difficult to make an examination of the eye, so violently do they resist the exposure of the eye to light. There is no definite relation between the severity of the disease and the intensity of these symptoms, for deep-seated inflammation may be present with but little or no inconvenience from them. The aggravations are usually in the mornings.

COURSE OF DISEASE.—If a single phlyctenule is present on the conjunctiva it may pass through all the phases up to complete recovery in a week or two. If several of these eminences are present then it may take a proportionately longer time. The disease would seldom last long if it limited itself to a single attack, but we have already seen that this is not the case, repetition being the rule, and this recurrence may go on for months or even years. Ordinarily it begins in childhood and continues intermittently up to around puberty when the attacks usually cease. Occasionally, however, it continues later in life. It is seldom that adults suffer with it that have been free from it during childhood, it being essentially a disease of children. After the disease has run a while, the lids become

inflamed (blepharitis) due to constant wetting by the excessive flow of tears. We may also have eczema of the lids; frequently we will find cracks and excoriations at the external angles.

PROGNOSIS.—Is favorable in so far as an eye is seldom rendered entirely blind by it. The deeper ulcerations usually leave scars behind, repeated attacks meaning numerous opacities which detract from the visual acuteness, while the slighter opacities may be entirely absorbed. A serious consequence is that the child falls behind in physical and mental development. Ignorant parents keep them in the house, and the children thus afflicted, of their own choice prefer inactivity and darkness. Of course the disease bars them from school, and in this way they fall behind their fellows.

ÆTIOLOGY.—This form of ophthalmia has its origin principally in the scrofulous diathesis, hence the name. The enormous majority of cases of the disease are found among the children of the poorer classes who receive insufficient or unsuitable nourishment. Their homes are damp, poorly ventilated, crowded and frequently dirty. The better class of children are attacked by it on recovering from such diseases as scarlet fever, typhoid, measles, etc. These children when attacked are still weak, pale and their tissues flabby; the salivary and lymphatic glands are usually indurated. In these cases blepharitis soon ensues, and we find the nose swollen and from it comes an excoriating discharge, irritating the already swollen lip. Occasionally we find the disease in an otherwise healthy child, just as the other isolated scrofulous phenomena are found.

TREATMENT.—If the focal point is on the corneal surface the first thing to bear in mind is the fact that the patient is suffering, sometimes intensely, and that the pain must be relieved as soon as possible, even if we are obliged to sacrifice scruples by making use of a local application, which should be resorted to at once after having first thoroughly satisfied ourselves that the agent employed is not contra-indicated. The one of all local remedies in scrofulous ophthalmia is atropia sulphate, used in varying strengths from $\frac{1}{2}$ gr. to oz. j. of water up to 4 grs. to the ounce, which may be instilled into the eye one drop three times a day, or even as frequently as every three hours, if the patient is carefully watched for the appearance of symptoms due to the physiological action of the drug. The atropia sulphate puts at rest all muscular action within the ball, thus making it passive, at the same time soothing the patient by its local anæsthetic effect.

By mentioning pain first I do not mean to say that it is of most

importance, but by using this means to allay the pain we have probably done the best thing, even if the condition is the gravest in connection with the disease, that of deep ulceration tending to perforation, except perhaps, when the perforation is liable to take place in the peripheral portion of the cornea, when the dilatation may possibly further a prolapse of the iris—a thing to be avoided if possible, for when it occurs it is a catastrophe to be dreaded. When the ulcer is so located it is probably best to make use of some myotic, such as eserine sulphate, or pilocarpine muriate for the purpose of contracting the pupil, and in this way keeping the muscular membrane tense and away from the seat of probable perforation. This form of ulcer may be headed off at times by carefully preparing the eye and then performing paracentesis of the cornea, by means of this procedure slowly drawing off the aqueous humor, and thus preventing the gush of water which carries the iris into the opening, there to become entangled. This operation may be repeated frequently, and for certain reasons it aids materially in the cure. A combination of remedies sometimes used by members of the older school is cocaine mur. et atropia sulph. You can readily understand why. Bandaging is, as a rule, to be avoided, except in the perforating ulcer, on account of its damming up the tears, they being liable to cause excoriations, an inflammation, or even an eczema of the skin surface of the lids. If possible, correct the mode of life; also when you can, surround them with good hygienic conditions; order a change of diet, and include absolutely nothing but good, plain, nutritious food, such as meat, vegetables, preferably fresh, etc. Reduce saccharine food to a minimum or do away with it entirely. Patients should have plenty of sleep, but while awake should be out in the open air as much as possible taking moderate exercise. Change to sea air, or from city to country, is often efficacious. To their baths, which should be taken daily and followed by good friction, may be added to advantage sea-salt. In the milder varieties of the disease we will have them yielding at once to this treatment. In a decidedly scrofulous patient, or one recovering from an exhausting disease, do not forget the use of cod-liver oil and stimulating foods.

I have left to the last the consideration of homœopathically applied drugs because you all know their sphere and that it is a large one I can assure you, and I believe that, while the annoying symptoms are held in abeyance by the local agents, the similar remedy may become the more effective. Those of most importance

are *ars. alb.*, when we have the terrible burning of the parts, with the characteristic thirst of the drug and considerable corneal infiltration; *merc. cor.* is indicated when excoriating discharges make the lids, nasal cavity and lip sore, and we have deep, rapidly eating ulcers; *kali bichrom.*, when the ulcers have a deep, punched-out appearance, the surface being covered with a dirty yellow, buck-skin-like coating; *graphites*, when the rhagadic condition is present, with the typical graphite eczema on the lids and behind the ears. In the scrofulous patients, remember *ars. iod.*, *calc. iod.*, *merc. iod.*, *sulph.*, etc.

Thus the treatment may be embodied under three heads: (1) local measures; (2) hygienic and dietetic care; (3) the homœopathic application of drugs. These three combined always prove an irresistible force in the treatment of the disease.

GNAPHALIUM IN RHEUMATISM.

BY W. H. MACDONALD, M.D., LAKE GENEVA, WIS.

MY first experience with gnaphalium in sciatica has led me to think well of this somewhat neglected remedy.

The case was that of a phlegmatic Scotch lady, about 65 years of age, who had received, as nearly all such patients do, a *very thorough* course of medication, all the way from athlophorus, until she was temporarily deaf, to quinine in 20-grain doses, until the church and fire-bells were ringing all the time. The attack ran a typical course for about three months. The pain, which had commenced in the hip, gradually located itself in the calf of the leg, where, with an occasional return to its original position, it remained the greater part of the time, and seemed of the nature of a cramp. Either heat or cold aggravated it. There was also an occasional pain midway between the anus and tuber ischii, but specular examination of the rectum revealed no marked trouble there. Profuse sweating was frequent, and during the occasional intermissions of pain the patient was nervous, sometimes almost to the degree of hysteria. Stomach and bowels in good condition.

I began with gnaphalium in rather heroic quantities, but the effect was brilliant. Ten drops of the tincture in water every four hours. After the first day there was no return of the pain, and I reduced the dose to five drops three times a day, and at the end of a week discontinued it. Since that time, now nearly a month, the pain has

returned, in a modified form, three or four times, but each time one dose of ten drops was sufficient to stop the pain entirely in about two hours, acting as an anodyne, but not in the least as a hypnotic.

CASE II.—Man, 35 years, from effect of an injury and subsequent exposure suffered intense pain along the sciatic nerve. He had taken phenacetine and salol from other sources for two days with temporary relief. As soon as the case came into my hands gnaphalium was applied in the same manner and with the same result. The relief was prompt and permanent. The good effect of the remedy seemed so decided, I deemed the case worthy of mention.

BREATHING IN ITS RELATION TO SINGING AND SPEAKING.

BY EDWIN H. VAN DEUSEN, M.D., PHILADELPHIA.

(Read before the Philadelphia Medical Club, March 1, 1893.)

PERHAPS I should offer an apology for presenting this evening, for the consideration of the club, some thoughts upon a subject concerning which I cannot hope to advance anything new, but my own deep interest in the subject and the evident confusion in the minds oftentimes of educated and competent voice trainers as well as physicians as to the best method of breathing, and the hope of making the subject clearer by means of a rearrangement of the physiological facts in the case, must serve as an excuse for the presentation of this, the fundamental element in vocal physiology.

It is unnecessary here to enter into a detailed discussion of the mechanism of respiration, but it is important to recall to mind the two chief factors in the act. It is plain that the introduction of air into the lungs depends upon the enlargement of the chest cavity and the expulsion of air from the lungs depends equally upon the diminution of the chest cavity. It is also plain that the enlargement of the chest cavity is produced by either the ascent of the ribs or the descent of the diaphragm or both, and the diminution of the chest cavity results from the descent of the ribs or the ascent of the diaphragm or both. The ascent and descent of the ribs are the result of direct action upon the movable ribs by muscles whose origin and insertion are either both movable, as in the case with the intercostal muscles, or one fixed and the other movable, as in the sterno-cleido-mastoideus and other similar auxiliary muscles. The ascent and descent of the diaphragm are the results of the compressing action of muscles whose origin and insertion are both fixed. When the

muscles of the diaphragm contract the diaphragm descends, the chest cavity is thereby enlarged and the abdominal cavity would be proportionately diminished, were it not that the muscular walls by their relaxation constitute a perfectly adjusted compensatory apparatus. Conversely, when the abdominal muscles contract they would by compression diminish the size of the abdominal cavity were it not for the proportionate relaxation and ascent of the diaphragm and consequent diminution of the chest cavity. The walls of the chest cavity formed by the ribs and connecting musculo-membranous masses are only slightly elastic, while the floor of the cavity, the diaphragm, is perfectly elastic and it surmounts a cavity which for our purpose is virtually an air chamber and whose walls are also perfectly elastic. According as air is introduced into the lungs by means of the ascent of the ribs or the descent of the diaphragm the breathing is spoken of as costal or diaphragmatic, as thoracic or abdominal. In health these two great factors of the one act are never divorced but the predominance of one or the other gives a character to the respiration which warrants the distinction. The so-called clavicular breathing need not enter into our subject.

The diaphragm is the central figure in the respiratory act and it must balance, on the one hand the action of the muscles of the thorax, and on the other hand the action of the muscles of the abdomen. Upon the perfection of the complementary action of these three elements depends the evenness of tone production and the sustaining power of the voice. Indeed, all voice culture that is not brain culture is muscle culture. The problem is how best to control the muscles.

With this somewhat aphoristic statement of facts in mind, let us review as briefly as may be some of the theories and practices of prominent vocal teachers and writers concerning methods of breathing.

Lennox Browne and Emil Behnke, in their last edition of their joint work, state the case in this way: "The combined forms of midriff and of rib breathing constitute the only right way, and collar bone breathing is totally wrong and vicious, and should not, in a state of health, be made use of under any circumstances." (Page 138).

"The criterion of correct inspiration is an increase of the size of the abdomen and of the lower part of the chest. Whoever draws in the abdomen and raises the upper part of the chest breathes wrongly." (Page 142).

"The air is the motive power upon which the voice depends; without air no tone can be produced. It is, therefore, of the utmost importance for singers and speakers to be trained to breathe properly. We must know how to inflate our lungs in order to fill them abundantly without over-crowding them, and without any effort causing fatigue and injuring the voice; and we must know how to regulate the exit of air so that it may take place in a steady, even and uninterrupted stream enabling us eventually to hold out a long tone, to sing a long passage, or to execute a fine 'Messa de voce.'" (Page 143). Then follow their excellent breathing exercises.

From Ghislani Durant's entertaining work *The Hygiene of the Voice*, 1879, I quote the following: "The peculiar art of speakers, and of singers especially, consists in great measure in the proper management of the respiratory apparatus. If we abandon ourselves to instinct, we all respire equally well, . . . but when the will intervenes, as in singing or speech, it may happen that one of those means (the various movements of respiration), may be exaggerated to the prejudice of another; in such a case we should strive to return to the normal type of breathing, or at least to use that type which is best suited to produce the desired effect." (Page 100).

"When, after an ordinary expiration, the ribs have been lowered and the diaphragm has returned to its normal situation, there yet remains a little air in the lungs which allows of a still further prolongation of the expiration. To produce this prolonged expiration, the abdominal muscles are called into action." That you may not think the author believes in totally exhausting the air from the lungs, I add a quotation from the succeeding page (103). "It is even necessary that a certain amount of air is always held in reserve in the lungs after the execution of each period."

J. Solis Cohen, in *The Throat and the Voice* (1879), expresses these somewhat similar views: "The best efforts of elocution and singing are produced from a full chest of air inspired according to the natural or abdominal type." (Page 139).

"The voice is produced only during an expiration (page 140), . . . but the expiration should not be prolonged unnecessarily, for that will deprive the sound of due volume and fulness towards the close of the expiratory effort." (Page 141).

I copy from the *Philosophy of the Voice*, by Charles Lunn, an extract which he has taken from MacKenzie's *Hygiene of the Vocal Organs*, because the edition of MacKenzie's work which I have con-

sulted does not contain exactly the statement quoted by Lunn. Lunn's second law is "Complete Inflation;" in other words, suck in as much air as can possibly be drawn in. . . . The following extract from Sir Morrell MacKenzie's *Hygiene of the Vocal Organs*, page 71, third edition, will show how false modern teachers act. The old Italian masters taught that in inspiration the anterior abdominal wall should be slightly drawn in, and this method was practiced for more than a hundred and fifty years; but in 1855 Mandl opposed this mode of breathing on anatomical grounds, maintaining that the descent of the diaphragm is facilitated by allowing the abdominal wall to be flaccid and to project forward in inspiration. In England the views of Mandl have been advocated by Messrs. Browne & Behnke and I was myself inclined to accept these doctrines. I felt some misgivings, however, on the subject, more especially as Gottfried Weber, one of the most acute investigators who has studied the science of singing, says that it is impossible to explain why it is so, but that undoubtedly the old Italian method is the best. In the early editions of this work I endeavored to harmonize the conflicting views, but further investigation of the subject has convinced me that the old *maestri* were right and that in the abdominal cavity there is ample room for the slight descent of the diaphragm without any protrusion of its anterior walls. I hope to publish the results of my experiments and observation before long, but in the meantime, I may remark that by the old Italian method complete control is obtained at the commencement of the act of expiration and undue escape of air, *i.e.*, waste of breath is thus prevented. In other words, by the Italian system, greater effect is produced with less expenditure of force."

Mr. Lunn then quotes the following from Garcia on *Respiration*: "In order to inspire freely, hold the head straight, the shoulders thrown back without stiffness, and the chest open, *raise* the chest by a slow and regular motion, and *draw in* the stomach."

In the 1886 edition of his book, MacKenzie thus attempts to reconcile the method of Mandl with that of the old Italian masters: "The contraction of the abdominal wall . . . may follow the act of inspiration, of which the descent of the diaphragm is an essential part, so closely that it may seem to the person himself to be a part of the act. If this view be correct, breath is *taken* by the diaphragmatic method and *retained* by contraction of the abdominal wall upon the descended diaphragm, thus in reality helping to fix that muscle and, consequently, to keep the lungs inflated."

The chief point of agreement among the authors quoted is in regard to the importance of a method of inspiration. All go into details. Even Mr. Lunn, who tells us to suck in as much air as possible without regard to diaphragmatic, costal, or clavicular breathing, enforces with italics the specific instructions of MacKenzie and Garcia. Another point of agreement is the marked avoidance of any statement of a method of expiration. There is also a perfect agreement in regard to the importance of breathing in relation to voice production. The disagreement is all in regard to the method of inspiration to be adopted, and it amounts even to controversy. This would seem to be unnecessary.

The object to be accomplished is the production of the best tone with the least possible expenditure of force. "The voice is produced only during expiration." (Cohen.) We have then to do with expiration as the motive power of the voice and with inspiration only as an important preparation for expiration.

Expiration.—In ordinary breathing, expiration is little more than a passive return to an original condition, dependent upon the external air pressure, the involuntary relaxation of the diaphragm, and the natural elasticity of the pulmonary vesicles. In voice production this would be utterly inadequate, since none of the elements are under the control of the will, and perfect voice production means perfect control of the force and volume of the air current. Volitional expiration is performed by the contraction of the abdominal muscles, the contraction of one set of intercostal muscles, and the relaxation of the diaphragm, which in this instance, of course must be involuntary.

In theory it is impossible to separate these three departments of the one act, and in practice it is the attempted separation which brings about such unpleasant results, whether the plan advocated be called abdominal breathing or the pupil be instructed to raise the chest and draw in the stomach. It may also be stated with just the same force, that it is only as a matter of convenience that we are warranted in separating the two acts of inspiration and expiration, for, as we shall see, contraction of the diaphragm, always considered as an inspiratory condition, has a very important part to play in expiration, since a flabby and relaxed diaphragm is incompatible with control of the breath, and elevation of the ribs, while most marked in inspiration, is very important in expiration in offering a fixed support for the diaphragm.

Perfect muscular control of the diaphragm is of the utmost im-

portance, and without it a singer or speaker can hope for only partial success. While the direction of the action of the diaphragm during expiration is toward relaxation, it must be constantly in a state of sufficient tension to control the force of the air column by resisting the action of the abdominal or intercostal muscles, or both, as the case may be. A state of passive relaxation is fatal to the prolongation or gradation of sounds. Then, too, since the diaphragm is the supporting base of the air column, its condition will influence very largely the character of the tone. It is a sort of a sounding-board, a banjo or drumhead, as it were, capable of being altered in tension at will. The carrying power of the voice depends very largely upon this tension of the diaphragm. We all have heard singers and speakers who seemed to those near by to be making a great effort and a great noise, and yet who could scarcely be heard at the rear of the hall. Such as these have poor control of the diaphragm. The expression of intensity of feeling, even if the tone is not loud, is an utter failure if attempted with a flabby diaphragm. Nothing but a living musculo-membranous mass could fulfil, for one instant of time, the requirements demanded. The economy of nature and the adaptation of means to ends are nowhere seen in greater perfection than in the study of the organs of the voice.

The usual involuntary action of the diaphragm, probably more than anything else, makes it a difficult muscle to bring under voluntary control, but it responds to education as readily as any of the purely voluntary muscles. It goes through the same stages: first, it is unruly; then, with careful direction and attention, it will do our bidding; and at last it acts with the precision of a machine and a promptness perhaps born of the spinal cord rather than the brain. Indeed, it becomes again an involuntary muscle, but thoroughly educated to a new purpose. We may become cognizant of the action of the diaphragm in many ways. To some, deep abdominal breathing reveals its action. To others, deep breathing is simply taking a big breath, absolutely nothing more. To these, perhaps, rapid, shallow expirations and inspirations, in imitation of a panting dog, may evince contraction and relaxation of the diaphragm, especially if continued to the point of a sense of fatigue. Some must forcefully distend the abdomen against a moderately tight waistband in order to apprehend contraction of the diaphragm. Still others experience diaphragmatic action best when, with closed mouth and nostrils, they alternately distend and retract the abdomen and, of course, also the chest. The mere act of clearing the throat by a rather prolonged

effort, is often sufficient indication of the resistance which the diaphragm is often called upon to offer to the expiratory action of the abdominal and chest muscles. Blowpipng, whether in chemical analysis or gas-fitting, also calls into play the same muscular action, but, of course, here the lumen of the tube also offers resistance to the air current. Perhaps blowing soap-bubbles would be a better exercise for our purpose. The voluntary action of the diaphragm is demanded for many purposes daily by everybody, but few of the unlearned recognize its action, and very few ordinary singers and speakers learn to make it subserve their purposes. Probably this is one, and perhaps the greatest, reason why there are so many ordinary singers and speakers, and so comparatively few who reach a higher plane.

Exercises recommended and used to secure this restraining power of the diaphragm over expiration have been numerous, because of the necessity of adapting to the pupil the form of exercise best suited to his needs, and this can most successfully be done by an intelligent and competent teacher. One successful teacher in Philadelphia instructed her pupils to sit upon the edge of the chair, with the chest forward, and back hollowed, and, after a deep breath, to make "a straining effort as if constipated," this to be followed by the explosive pronunciation of the word *pa* or *ba*. Another tells her pupils that in singing they must not feel as though air was escaping from the mouth, but rather as if it were being taken in. Probably this means that they must be more conscious of the restraint than of the expelling power.

This subject is discussed very fully by Oskar Guttmann in his *Gymnastics of the Voice*. He advises to practice in the following manner: "After the lungs are completely filled, retain the air in them two or three seconds and then emit it slowly through a very thin blowing tube. Repeat this exercise six times in succession, three times a day, and do not proceed to the 'second series' until after the lapse of two weeks, while the time for holding the breath grows gradually longer, thus: five seconds for four days, ten seconds for eight days, twenty seconds for sixteen days, twenty-five seconds for thirty days; then practice on thirty-five seconds for six weeks and not until after two or three months make any attempt to hold the breath from forty-five to sixty seconds, and this latter number only if it can be done with ease; under no circumstances is force to be applied."

It is proper to state that although I am not really indebted to

the work of Mr. Guttman, since it is only within the past month that I have become acquainted with his book, yet the theories and practices which he ably advocates are almost identical with the conclusions at which I had arrived a year or so ago. His work was first published in English in 1882 and in German twenty-three years before, and an earlier acquaintance with the book would have saved me much thought and work. I would not, however, have appreciated his works as fully as I do now, for, as in the material world, so in the realm of thought, the value of the product is influenced by the labor required.

Almost every work on the voice contains here and there a phrase pointing in this particular direction and almost every singer or teacher of note gives at times some indication of the road to be travelled, but few feel it to be as important as does Mr. Guttman, or they would not be satisfied to dismiss the subject with a few words or phrases. Many others, while owing their success to proper breathing, have acquired the method by imitation or accident and are unable to correct breathing defects in their pupils. It is necessary to be something more than a good singer in order to be a good teacher. Messrs. Browne and Behnke recommend three excellent breathing exercises. The first consists in a slow, steady and deep inspiration and after retaining the air a few seconds a sudden expiration. The holding of the breath must not be by shutting the glottis, "but by keeping the midriff down and the chest walls extended." The result of suddenly letting the breath go will be the flying up of the midriff and a falling down of the ribs. The second is the reverse, that is a rapid and full inspiration and a slow, even, uninterrupted expiration, not jerking or trembling, and the third is a combination of the two, a slow inspiration and a slow expiration. In connection with the second exercise, which especially concerns us now, this statement is made: "A little consideration will show that it is wrong to try to control the exit of the breath, as some would have us do, by a contraction of the glottis, because the comparatively tiny muscles of the larynx are too weak to resist with impunity so tremendous a strain, while the large and powerful muscles of the chest are clearly made to regulate expiration as well as inspiration. It is absurd on the face of it to suppose that they are only intended for inflating the lungs, while the exit of the air is to be governed by another set of small muscles situated at a great distance and having their full share of work in the marvellous and ever varied combinations which are necessary in the production and gradation of tone."

Is it not strange that these authors should tell us to hold the breath by keeping the midriff down and yet, when it comes to expiration, not mention the diaphragm, but contend that the large and powerful muscles of the chest are clearly made to regulate expiration? The great utility of this second exercise is the control it gives one over the breath from the resisting action of the diaphragm. It is utterly useless if this object is defeated. The exercise of the large and powerful chest muscles in expiration makes the air current whether silent or vocal, uneven, interrupted, jerking and trembling, but since the advocates of the exercise have directed explicitly that these objectionable features should be rigorously guarded against in its performance, they have fortunately killed the legitimate offspring of their own theory before birth. A little later they suggest the practice of this exercise before a candle flame as an index of the steadiness of the air current. Perhaps blowing soap bubbles will answer all the requirements of exercises two and three, and as a substitute for Guttman's exercise, with possibly some advantages over all. It supplies a better indicator than the candle flame, a tube of larger lumen than Guttman's and an interesting amusement as well; at least it is less monotonous than the other exercises. Whatever the exercise selected for the purpose, the object must be kept in mind and if the practice be faithful and persistent success will crown the effort. As in the training of any other muscle, time, patience and perseverance must be wedded to well-directed effort.

The control of the abdominal muscles is just as necessary and important, but much more easily obtained. Every expulsive effort calls them into action. The exercises used to induce control of the diaphragm bring about at the same time control of the abdominal muscles. Indeed, the objection to all the exercises proposed is the possibility of their cultivating the abdominal muscles to the exclusion of the diaphragm. In the Browne-Behnke exercise the gentle expiration may be produced by extreme gentleness of the action of the abdominal muscles and not evenness of resistance of the diaphragm. So in the Guttman exercise, the small lumen of the tube may be made to supplant diaphragmatic action by offering the resistance. So also, in blowing soap bubbles, even with a tube of large calibre, the abdominal muscles may withhold active contraction. It is absolutely necessary to bear constantly in mind the importance of the counteraction of the diaphragm as well as the action of the abdominal muscles and not to cultivate one to the exclusion of the other.

In expiration the ribs should not be permitted to descend too

soon. They should be retained in the position assumed at the beginning of the expiratory act until perhaps one-third of the air has been exhausted. They should then be permitted steadily and gently to descend, during which time the abdominal muscles remain in a state of comparative quiescence and after the ribs have reached their normal position, the remainder of the expiration is performed by the abdominal muscles. It is necessary that the ribs should remain elevated during the first part of expiration to act as a fixed and steady support to the diaphragm as well as to avoid the necessity of its extreme contraction. When relaxation has reached the limit of control, when further relaxation would mean flaccidity, the descent of the ribs enables a renewed contraction of the diaphragm and a consequent renewal of control. The uneven, gasping tone often heard at the end of a long phrase is usually the natural outcome of an attempt to squeeze out a little more air with the ribs after the diaphragm is perfectly relaxed and the abdominal muscles are contracted to their utmost extent. Speakers and especially preachers are greater offenders in this particular than singers.

Inspiration.—With a thorough understanding of what is to be accomplished, the preparation should not be difficult. Inspiration preparatory to singing or speaking should be performed in such a way that at the completion of the act the organs will be in the best condition for the production of the succeeding expiration. The ribs should be gradually raised and the abdomen should be moderately distended. This is the natural deep inspiration practiced by everybody—at least, during sleep. The raising and expanding of the ribs increase the size of the chest cavity and offer a support for the complete contraction of the diaphragm, which, in turn, enlarges the chest cavity to its greatest capacity. The contraction of the diaphragm necessitates the distension of the abdomen, and here again it is necessary to caution against permitting the muscles to become completely relaxed or flaccid. If the abdominal muscles are not constantly in a state of tenacity, following the contraction of the diaphragm accurately, there will be a period of muscular contraction preceding the expiration, a taking up the slack in the abdominal muscles as it were. This produces an awkward motion, if nothing more, and usually, also, an unsteadiness of tone and escape of air at the beginning. Of course, a relaxed abdomen is not the only cause of faulty attack, but it is a very fruitful one, and often overlooked.

A lady who recently sang very creditably before a Philadelphia audience possessed the peculiarity in a very marked degree. Her abdomen needed no distension to make it ample. Her attack was

good and there was no breathiness and no gasping, but every hasty inspiration was terminated by a noticeable movement of the abdomen and a jarring of the glossy satin front of her dress as if she had raised herself on her toes and suddenly dropped upon her heels. It must have taken long study to produce a steadily-commencing tone with that motion, and a little less abdominal relaxation during inspiration would have saved much time and prevented the one objectionable feature of an otherwise excellent performance.

Some years ago I presented to the museum of the Hahnemann College a monstrosity lacking abdominal parietes. It is probable that the peritonæum was intact up to the time of birth, and that during delivery it ruptured. At any rate, as soon as delivery was completed the absence of retaining walls for the intestines was a source of considerable annoyance. There was no opportunity to consider the trouble or to attempt to remedy it before the loss of another function of the abdominal walls presented a graver difficulty. Breathing was impossible; a couple of gasping attempts at filling the lungs were all that could be induced. The diaphragm had no complement, no resistance. Its action was as irregular and as futile as the blow of the pugilist who misses his mark or the stroke of the oarsman who catches a crab. It was worse; for the arm may be withdrawn and the seat regained, but relaxation is not replacement, and the counteraction here was lacking. It was like the Asra. It performed its ordained and highest function, and in so doing destroyed the possibility of continued existence.

The perfect poise, balance, equilibrium, co-ordination, complementary action, adjustment, resistance, antagonism, or any other word which will interpret the idea, which must exist between the diaphragm and the other parts of the respiratory apparatus is only the same kind of action as is demanded of any other antagonizing sets of muscles in the production of their best efforts. The well-trained athlete is not merely the man of large muscle. He is the man of perfect co-ordination, whose muscles are perfectly complementary in their action. When he jumps are the flexors relaxed? When he pulls an oar is the triceps relaxed? All his muscles follow every motion as closely as a needle follows the magnet. The eye detects any failure in physical culture very quickly. It is called ungraceful action, labored effort, bad form, over-training, and other names no more specific. The ear, even untrained, very quickly notices defects in voice, whether in speech or song, but having become so habituated to bad habits and methods in speaking, we look upon what is usual as being natural, and cease to criticize, although unable

to commend. With the voice in song, however, criticism continues, and it is to be hoped that its cessation will never result from despair of improvement. Unfortunately, the criticism is for the most part merely an expression of restless dissatisfaction and, therefore, not very fruitful of results, but it serves to stimulate to greater effort, for approbation is an inborn desire of the heart. The ear recognizes the fault, but fails to locate it. A good musical critic is often neither a good singer nor a good teacher. The well-trained vocalist must possess this harmonious muscular antagonism in its greatest perfection. There must be neither straining nor flaccidity of any part. (Emotional exigencies constitute the only exception to this rule.) There must be no distressing evidences of effort. The red face, the swollen neck and violent heaving of the chest are as painful to the listener as to their possessor. There are other evidences of effort which appeal to the ear alone, and which are only a little less distressing, and many singers devote much time and patience, with considerable success, to the removal of these evidences. They learn, after a while, to smile and look pleasant while making the most heroic efforts to squeeze out a little more air to complete the phrase. The same amount of time and patience devoted to relieving the necessity for effort would produce vastly superior results.

Permit a brief recapitulation :

Breathing is of the utmost importance in tone production.

Tone is produced only during expiration.

Expiration, in order to be under perfect control, must be performed by the contraction of the chest and abdominal walls, counterbalanced by the relaxing yet evenly-resisting diaphragm. During the early part of the act the diaphragm must be supported by the distended lower ribs, but as the act proceeds the ribs must descend to diminish the size of the chest cavity and to enable a renewal and longer continuance of control of the diaphragm. The close of the act must be performed by the abdominal muscles and the diaphragm for, especially at the close of expiration, tone produced by chest contraction is uneven on account of the comparative inelasticity of the chest walls. The diaphragm must always be in a state of tension, not only to control the air current by resisting the action of the abdomen and balancing the motions of the chest, but also because its condition influences the tone quality.

A natural full inspiration, raising and distending the lower ribs and moderately distending the abdomen, is the best preparation for proper expiration.

EDITORIAL.

MEDICAL LEGISLATION IN THE UNITED STATES.

MEDICAL legislation is rampant in every section of the country. It is instigated by allopathic physicians for the purpose of gaining the *control* of medical licensure. In California there has been a bitter contest—the allopathic physicians introduced a bill into the legislature providing for the appointment of a State Board of Medical Examiners to be composed entirely of allopathic physicians, who were to have the exclusive control of issuing licenses to practice medicine in the State. It was the same old story that has been repeated with tiresome regularity in nearly every State of the union, with the same purpose and object—to acquire control over their rival schools. Their secondary purpose is without doubt to conserve public interest by diminishing the influx of improperly qualified practitioners. But so heedless are they of this latter object to promote the interest of the public, that if they are deprived of the majority control on these proposed boards they will wreck any legislation providing for the elevation of the medical profession that is within their power. In California their unrighteous bill was introduced and passed to third reading before its existence was known to the homœopathic and eclectic physicians. When these physicians in self-defence strove to secure recognition of their rights by amendments designed to give to each school equal representation, the framers of the bill immediately defeated their own pet scheme and then complained, as do the allopathic physicians in the East, that the homœopathic physicians are as stubborn and as unreasonable as they themselves were twenty years ago, that they really do not desire the supervision of homœopathic candidates, nor do they object to the requirement that no one school shall ever hold a majority representation on a single board of examiners; they only fail to recognize the *necessity* of such a provision. This is the position they have brought themselves to in Pennsylvania. The Judiciary General Committee of the House of Representatives of Pennsylvania tired to the limit of endurance by the unyielding position of the allopathic profession, reported to the House a bill to establish three separate and distinct boards of medical examiners, one for the homœopathic, one for the allopathic, and one for the eclectic school of medicine, with a super-

vising council of five members composed of State officials, the Lieutenant-Governor, the Attorney General, the Secretary of Internal Affairs, the Superintendent of Public Instruction, and the President of the State Board of Health. If the allopathic physicians oppose or try in any way to defeat the passage of this bill, their pretext will become bare, and the odium of trying to defeat medical reform in Pennsylvania will be theirs. The bill now before the House of Representatives of Pennsylvania has as its object the divorcing of the teaching from the licensing power, and will afford the best possible opportunity for enabling the profession to attain a higher and more nearly uniform standard of medical learning. At the same time it amply protects the public and provides effective means for permitting the three representative schools to *separately* exercise the civil right to conduct, control, and complete, each under its own supervision, yet under conditions and standards applicable to all alike, *its own medical educational affairs*.

On going to press, we learn that in conformity with a request signed mutually by the Chairman of the Legislative Committee of the Allopathic State Medical Society and by the Chairman of the Homœopathic State Medical Society, an act passed second reading to-day, without opposition, to establish a *Medical Council of Pennsylvania*, consisting of five State officials (as mentioned above) together with the presidents of three separate boards of medical examiners to be appointed for the State of Pennsylvania—one representing the Medical Society of the State of Pennsylvania, one representing the Homœopathic Medical Society of the State of Pennsylvania, and one representing the Eclectic Medical Society of the State of Pennsylvania; each board to consist of seven members; the Governor to appoint the members respectively from lists of the members of the said medical societies. The bill comes up for third reading on Tuesday, March 28, 1893.

An absurd proposition has been introduced into the Legislature of Illinois to create a single Board of Medical Examiners, to consist of nine allopathic physicians, one homœopathic physician and one eclectic physician. A united request upon the part of the homœopathic physicians of the State of Illinois for a separate board, with a general supervising committee or council, will be readily granted by the Legislature of their State. The same is true of Connecticut and of every other State where the subject of medical legislation is being agitated.

THE EDUCATION OF PARENTS FOR THE SAKE OF THE CHILDREN.

DR. WINTERBURN, the editor of *Childhood*, is doing a noble work for humanity in directing the attention of parents to an intelligent appreciation of the proper development of children. As a means for obtaining a wide-spread diffusion of this desirable object, he has secured the association of George Ticknor Curtis, John Scribner, Elbridge T. Gerry, Daniel Greenleaf Thompson, Mrs. Louise Chandler Moulton, B. O. Flower (editor *Arena*), Prof. George Trumbull Ladd (Yale), President G. Stanley Hall (Worcester), Dr. William Tod Helmuth, Prof. Joseph Rodes Buchanan, and many others, in forming the "The Parents' Association of America," the object being to afford to parents opportunities for co-operation and consultation, so that the wisdom and experience of each may be made profitable for all. To create a correct public opinion on the subject of the training of children; to scatter broadcast, for the education of parents of all classes of society, the best principles and methods of education in all its aspects, dwelling with particular emphasis on those concerned in the formation of habits and character, and to secure a harmonizing of home and school training. The forceful effectiveness upon the elevation of the human race of such an organization, if carried to its proper limits, appeals to the active aid and support of every physician in the land to organize and foster local branches. It is the duty of the family doctor to lead all such movements, and this is a vital one, as it reaches the root of one of the greatest evils of the age—the improper development of children. We refer our readers to the pages of this month's *News and Advertiser* for a complete report of the association and "For the Children's Sake," invite their sympathy and co-operation.

ACHILLODYNIA.—Prof. Albert, of Vienna, describes under this name a rare affection characterized by violent pain at the point of insertion of the tendo-Achilles. Walking or standing is accompanied by violent pain at this region, while on sitting or lying it completely disappears. Objectively, a small swelling is to be seen as though the place of tendinous insertion were thickened. It is of the same hardness as the tendon and but little painful on pressure. Sometimes the bone itself appears to be laterally affected. The pain is very obstinate to treatment of all kinds. No cause to be discovered. Gonorrhœa may be of ætiological importance.—*Wiener Med. Presse*, No. 2, 1893.

NAPHTHOL AS AN ANTHELMINTIC.—Dr. Dubois had a young girl, 16 years of age, who vomited continually, and, as no other cause could be discovered, it was ascribed to worms. Various worm remedies were tried in vain until, from her persistent vomiting, and being unable to retain food, she became emaciated, and a slight fever set in. Seven grains of naphthol were then administered in three doses, and in a few days she passed thirty-four round worms and recovered her usual health.—*Le Bulletin Médical*, No. 2, 1893.

GLEANINGS.

GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D., AND FRANK H. PRITCHARD, M.D.

STAMMERING HEART.—Dr. R. E. Dudgeon, London, lumps together, under the name of “stammering heart,” a number of cardiac affections of a non-dangerous nature characterized by irregularity of action, without ascertainable organic disease, valvular or muscular. It is claimed that modern pathology does not supply the slightest clue in regard to this condition that can be of use for therapeutical purposes. Irregularity of heart action is not always without a perceptible pathological cause. Pneumonia and asthma usually show this condition and accumulation of flatulence in the stomach is a frequent cause. Valvular and kidney diseases are rarely without it, but this irregularity is different from “stammering heart.” The writer terms all the irregularities of the heart’s action, without demonstrable pathological cause, “stammering heart.” The affection may occur in earliest infancy to advanced age. The common typical variety of this affection is seen in the intermittent pulse. Stammering heart frequently becomes regular in its action if the circulation is hurried by exertion, wine or any febrile attack. In this it differs from the irregularity attending heart disease, which is usually unaltered when it is not increased by such causes. An intermittency of the heart’s beat, especially when it preserves a sort of rhythmic regularity and is not attended by weakness of the heart’s action, is not to be looked upon as of importance. The idea that the intermission is a rest during which the heart acquires fresh vigor deserves consideration, as the next beat after an intermission is generally stronger than the other. Intermissions are usually not perceptible to the subject of them, although sometimes a more or less distinct momentary obstruction is felt during the intermission, amounting even to distress and pain. The writer states that the extremely irregular character will be maintained for months and even years at a time, and then, without ascertainable cause, the pulse will become quite regular, and remain so, with an occasional but rare intermission, for as long a period. The practical importance of recognizing the stammering heart is to be able to allay the fears of patients who may find that their heart is acting eccentrically, where it is really of no pathological significance. Exciting causes of stammering or stuttering heart seem sometimes to be tobacco smoking or tea and coffee drinking. The affection being more a habit than a disease is not very amenable to medicinal treatment. Dr. Dudgeon recommends smart exercise, a glass or two of wine, digitalis, strophanthus, cactus, especially “cactina pellets,” will sometimes rapidly restore the regular action of the heart, but as often it pursues the uneven tenor of its way without heeding the remedies administered. The best thing to be done where the irregularity is not connected with any disease of the heart is to positively assure the patient that the stammer is not dangerous, and that he has no need to lay himself aside as an invalid, with anticipation of sudden death.—*The Journal of the British Homœopathic Society*, January, 1893.

THE PULSE IN HÆMORRHAGES IN TYPHOID FEVER.—Dr. Chrétien has remarked that, in several cases the hæmorrhages of typhoid fever were preceded by a dicrotic pulse. This was often to be observed a few days before their appearance, and it is easily explained by an elevation of the arterial tension. Therefore, to prevent the accident lower the heart-rate and the consequent arterial tension. The editor, in a foot-note, points out that in hæmoptysis of pulmonary origin there is a similar state of the pulse which persists during the entire attack. Also in two other hæmorrhagic cases, one an intestinal hæmorrhage and the other an epistaxis, this same pulse was noted.—*La Tribune Médicale*, No. 1, 1893.

THE PERMANENT SLOW PULSE.—Prof. Cornby has observed several cases with

a continuously slow pulse—the so-called Stokes-Adams' disease. The affection is characterized by three cardinal symptoms:

1. Decreased pulse-rate; 2. Fainting attacks; 3. Epileptiform attacks. The urine is lowered in quantity and albuminous. The disease attacks chiefly old people of both sexes. Heart diseases, syphilitic and brain affections are the causes. The pulse-rate ranges between 60 and 20, yet it may sink lower during the attacks. Respiration is not slowed. The disease is of long duration and the prognosis unfavorable; death may suddenly occur during an attack. The diagnosis must be based upon the presence of the above mentioned symptoms and the absence of any temporary depressing cause. The writer regards the disease of bulbar origin and the associated symptoms as uræmic. No treatment has, as yet, succeeded in raising the pulse-beat. The general condition and other symptoms are improved by a strict milk diet. During the attacks ether and amyl nitrite are indicated. In case of suspected syphilis try the iodide of potash.—*La Semaine Médicale*, p. 265, 1892.

PLEURITIS.—Dr. Ludwig Ferdinand, Prince of Bavaria, has examined 25 cases of pleuritis, and concludes as follows:

1. Most serous exudates contain no bacteria.
2. The majority of exudates without bacteria are of a tuberculous nature.
3. There are serous exudates containing pyogenic bacteria, which yet remain serous. This does not hold good of the streptococcic exudates.
4. Most empyemas are due to the streptococcus pyogenes.
5. A lesion of the lung usually precedes the pleural affection, yet a pleuritis may originate from toxins or traumatism.

Serous metapneumonic exudates present the best prognosis; then follow serous staphylococcic exudates, and, in increasing gravity, metapneumonic, primary staphylococcic, primary streptococcic exudates, and purulent empyemas last. Tuberculous and septic exudates have a bad prognosis, on account of the basic disease.—*Wiener Med. Presse*, No. 5, 1893.

THE PULMONARY COMPLICATIONS OF ACUTE TONSILLITIS.—Dr. Richardière has studied the pulmonary complications of acute tonsillitis. All varieties of the disease may have these complications: phlegmonous tonsillitis; tonsillitis with small isolated abscesses in the interior of the gland or with suppuration of the surrounding tissue, descending into the mediastinum and passing round the pharynx. The local symptoms of tonsillitis are usually not intense, and the tonsils usually not much swollen. The most frequent complication is pleurisy, which is always purulent. It may be unassociated with any other pulmonary complication or be accompanied with broncho-pneumonia. Pneumonia is less frequent. Pulmonary congestion is also observed, sometimes with signs of paralysis of the phrenic or pneumogastric nerves. The prognosis of these tonsillitic complications is extremely grave, as they point to a general infection of the organism. Hence death is ordinarily the rule, and if one recover the convalescence is very slow, with occasional muscular atrophy, such as is seen after infectious diseases of long duration. All the cases of pleurisy have ended fatally. These complications are visceral localizations, which are comparable to the meningitis or the otitis complicating pneumonia.—*La Tribune Médicale*, No. 5, 1893.

THE MISUSE OF MILK DIET IN ALBUMINURIA.—Drs. Lécroche and Talamon call attention to the present tendency to place all albuminuric patients immediately upon a strict and exclusive milk diet. A milk diet is insufficient, on account of a lacking amount of carbohydrates to fulfill the requirements of daily life. At any rate, four quarts would be necessary to cover this deficiency. No human stomach can carry out such a prescription without bringing down upon it both gastric and intestinal disturbances and consequent exhaustion, insufficient nutrition and anæmia. A milk diet would be sufficient for a bed ridden patient, but not for one up and about, and as three-fourths of those with albuminuria are in active life for months and years, if one prescribe such a patient milk, it should be as a drug and not as a food. These authors regard it as nonsensical to order a milk diet in the stage of remission of Bright's disease, where the only symptom is albumin in the urine, the quantity of urine is increased or even normal and the urea and uric acid keep within the normal. In case one has, by the milk diet, calmed the acute irritation of the kidneys and polyuria be present, insuring freedom from accumulation of the excrementitious matters in the blood, a continuance of the milk diet will not cause the albuminuria to disappear completely. In support of this they cite several

cases where, in four cases a long-continued milk diet was of no service and in two was injurious. Hence it is only indicated where one will increase the urinary secretion—firstly, in acute nephritis of any origin, and secondly, in acute exacerbations of Bright's disease. Even in these cases one must discontinue at the right time; one must not attempt to force every trace of albumin to disappear. In general, one may state that 8-14 days will do all that is possible with this means. Finally, in slight albuminuria from uric-acid-emia, gout or acute infectious diseases, it is not only unnecessary, but absolutely injurious, on account of its producing grave digestive and nutrient disturbances.—*Médecine Moderne*, No. 4, 1893.

A SENSITIVE TEST FOR THE DETECTION OF BILE IN THE URINE.—Dr. H. Rosin recommends the tincture of iodine as a sensitive test for the detection of biliary pigments in the urine. The other tests have the disadvantage of being difficult to execute and impractical. In some cases the mere addition of 1-2 drops of the officinal tincture or of a strong solution of iodine and the iodide of potash will suffice to color the urine green when the pigments are present. But when mere traces are present, a 10 per cent. alcoholic solution of the tincture of iodine will give, when carefully added to a test-tube containing 2-3 cm of urine and held at an angle, a grass-green ring between the layer of iodine solution and the urine. This will often persist for hours. The test is easily made, the reaction prompt and the solution easily made and kept.—*Berliner Klinische Wochenschrift*, No. 5, 1893.

TRIONAL, under quite recent clinical tests, is found to have a special value in uncomplicated agrypnia, or wakefulness with a certain amount of excitement. In these cases it is said to have acted promptly and effectively in doses of 1 to 2 grammes. Trional is useful also in convalescence from the abuse of cocaine and morphine. Some of the reports state that doses of 2 grammes would usually procure for these patients a sleep of from 7 to 9 hours duration. According to a recent report by Boettiger, dementia with hallucinations was very favorably influenced by trional. The same writer reports 33 cases of insomnia, with physical disturbances in the insane. These were primary or secondary, or were accompanied by moderate delirium or motor restlessness. Doses of 1 to 2 grammes of trional promptly induced a sleep of 6 to 10 hours. The full report of the cases referred to was published in the *Berl. Klin. Woch.*, No. 42, 1892.

THE VALUE OF LOSOPHAN as a remedy in cutaneous disorders seems to depend chiefly upon its influence in the dermato-mycoses. Saalfeld has lately described some very satisfactory results from the use of losophan in herpes tonsurans, pityriasis versicolor, and diseases determined by certain parasitic influences. He also derived favorable effects from its employment in prurigo, chronic infiltrated eczema, sycosis vulgaris, acne vulgaris and rosacea. Losophan seems to be contra-indicated in some of the inflammatory dermatoses on account of its marked effects as a dermatic stimulant. It is used in 1 to 2 per cent. solutions of a mixture consisting of 75 per cent. of alcohol with 25 per cent. of water. An ointment is also employed containing 1 to 2 parts of losophan in 98 or 99 parts of lanolin or vaselin. Chemically, losophan is a tri-iodocresol which results from the action of iodine upon m-oxytolnic acid in an alkaline carbonate or hydrate. It contains about 80 per cent. of iodine.—*Therap. Monats.*, October, 1892.

THE ARTICULAR COMPLICATIONS OF ERYSIPELAS.—Dr. Richardière divides them into three groups:

1. Sometimes during the course of, or convalescence from, erysipelas, one will observe a joint to be attacked. Only one will be affected; the effusion will be purulent and be more or less distant from the erysipelatous patch.

2. In the second variety the arthritis is a local complication of the erysipelas, and it is due to deep penetration of the micro-organism. This complication is serious, as it is suppurative and prolonged. They resist the salicylates.

3. The third group are multiple, almost always benign, mobile and unstable, without any well-marked general symptoms, and yield rapidly to the salicylates. They usually are observed in those with a history of previous acute rheumatic attacks. They are really of a rheumatic and not an erysipelatous nature, and indicate an awakening of the rheumatic diathesis. In some cases a generalized acute rheumatic attack will set in after erysipelas, the former disease acting as an awakening cause of the latent disposition. These attacks are of a moderate intensity.—*Le Bulletin Médical*, No. 6, 1893.

GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D.

PYÆMIC THROMBOSIS OF THE LATERAL SINUS FOLLOWING OTITIS—Pritchard and Cheate (London) record an interesting, instructive and successful case. Such cases invariably die without surgical interference, and the symptoms should be generally understood.

The patient was a healthy, well-developed girl of thirteen, with a history of left purulent otitis during infancy, which had ceased, however, some years before. Nine days previously there had developed, without obvious cause, earache and pain on the left side of the head, particularly behind the ear, and down the neck, especially on motion. This increased until it became agonizing and constant, preventing sleep. Vomiting appeared early and was persistent. Rigors occurred several times daily, and twitchings of the right leg were noticed during sleep. The child was restless, but answered questions well. There was no swelling, redness or œdema of or about the ear; slight tenderness was elicited by percussing at a point two and one-half inches behind the ear, and this was much more marked on palpating the upper part of the neck, which was swollen but did not fluctuate. The membrana tympani was dry, its vessels congested, but it did not bulge. There was no optic neuritis. The temperature varied from 102° to 105°, pulse and respiration being accelerated (about 120 and 40 respectively).

The mastoid antrum was opened with the chisel in the usual way, and the sinuses scraped out. Gas and a little thick caseous pus were found. The skull was trephined behind the ear, and the opening enlarged backward; more cheesy pus was removed. The bulging temporo-sphenoidal lobe was exposed and punctured, with negative result, and the dural incision sutured. The lateral sinus was punctured without obtaining pus, but the needle was found to have a very offensive odor. On laying the sinus open, fetid gas bubbled up, and exploration with a probe in either direction caused no bleeding. The sinus was scraped and washed out, and the internal jugular divided between two ligatures in the neck, the vessel being found collapsed.

Improvement was marked, but the temperature, which came down at first, kept rising, and on the third day a second operation was undertaken. The sinus was more freely exposed, its outer wall excised, and it was thoroughly scraped until a point was reached where bleeding appeared, this being arrested by pressure. The jugular vein was again exposed and dissected out as far as possible in the direction of the skull. Bichloride solution was then run through the sinus out of the vein; suture, with subsequent opening on account of abscess in the neck, and continuous convalescence.—*Lancet*.

CEREBRAL ABSCESS FOLLOWING OTORRHOEA.—Terrillon reports the following case:

Male, forty-six years old, had suffered from continuous otorrhœa for ten years; was taken with pains in the temporal region, vertigo and tendency to syncope. These symptoms increased progressively for a month, being worse at night. After an aggravation of the headache, coma developed, with rise of temperature. The skull was trephined an inch and a quarter above and a little in front of the auditory meatus. By a puncture two inches in depth, directed posteriorly, followed by incision, about an ounce of greenish-brown pus was evacuated. The temperature fell, the coma disappeared on the third day, and the patient recovered in three months.—*Le Bulletin Médical*.

LAVAGE OF THE STOMACH IN ACUTE INTERNAL INCARCERATIONS.—Pollak (Buda-Pesth) has tried washing out the stomach in seven cases, of which five recovered and the other two died of intercurrent disease, the intestine having been rendered permeable.

The indications are as follows:

1. Occlusions from coprostasis, enteroliths, gall stones, and foreign bodies, when not too large; kinks or axial twists of the intestine, or pseudo-membranes causing incarceration. It is especially indicated when the cause of the occlusion is known or its location is in doubt.

2. As a palliative measure when the time for operation is passed, on account of general prostration, and when an operation is refused.

3. As a preliminary to operative interference it is particularly useful in decreasing the abdominal pressure.

Lavage may be used for two or three days—at the most four days—from two to four times daily. If at the end of this time the gut still remains impermeable, an operation should be at once undertaken. [We question the advisability of such a long delay, even though lavage relieve the urgent symptoms.—EDS.] The rectum is also irrigated and opium given internally. Ewald's tube is used in washing the stomach, no cocaineization of the pharynx being necessary. An injection of camphor is of use before each lavage. Pure lukewarm water is used, and the washing continued until it returns clear.—*Ortosi Hætilap*.

TREATMENT OF PERITONEAL TUBERCULOSIS BY LAPAROTOMY.—Poncet (Lyons) reports a successful case of abdominal section for miliary tuberculosis of the peritonæum. The patient, a nine-year-old girl, was almost moribund, could not stand alone, suffered from intense dyspnoea, could barely answer questions; the abdomen was distended and very sensitive to pressure. Section let out nearly a quart of fluid and showed the parietal peritonæum, intestines and mesentery to be covered with innumerable nodules varying in size from that of the head of a pin to that of a pea. The fluid contained tubercle bacilli. About a drachm of iodoform was dusted over the peritonæum and the abdomen closed. Recovery was rapid, and at the end of five months the child could hardly be recognized, looking hearty, sleeping and eating well, and being free from pain. There was still some enlargement of the abdomen, but no accumulation of fluid or dulness on percussion.—*Le Bulletin Médical*.

TREATMENT OF TUBERCULAR PERITONITIS.—Mosetig-Moorhof (Vienna) asserts that the favorable results obtained in tubercular peritonitis from laparotomy are chiefly due to the penetration of air into the peritoneal cavity, this serous membrane being very sensitive to the irritation thus produced. A four-year old boy came under his care, with a great amount of ascites, hydrocele of the cord, and nodular induration of the epididymis and vas deferens, evidently of tubercular origin. The testicle was removed, the vas deferens resected as high as possible, and a drainage-tube, of the size of a lead-pencil, pushed up along the dilated sheath of the spermatic cord into the peritoneal cavity. By means of a double-bulbed apparatus, aseptic air was forced into the abdominal cavity until it was moderately distended. The tube was then compressed, the child held in a half-upright position, and the remaining fluid and air allowed to escape. Suture and an antiseptic dressing. The wound ran an afebrile course, the ascites reappeared, to be absorbed a little later, and three weeks after the operation he was sent home cured. Since then, he has been in good health, with no signs of ascites. The writer advises a trial of simple paracentesis of the abdomen, with subsequent insufflation of aseptic air, in tuberculosis of the peritonæum, especially where there is a great quantity of fluid present. It is easily performed and not dangerous.—*Wiener Medizinische Presse*.

RUPTURE OF THE SMALL INTESTINE CAUSED BY A TAPEWORM.—Dunlap (Danville, Ky.), reports a unique case:

A young woman was suddenly taken with left iliac pain and symptoms of collapse, which, with a boggy tumor that could be made out in this region, led the reporter to make a section for supposed ruptured tubal pregnancy. The pelvis was full of clots, but the uterus and adnexa were normal. In flushing out the clots some eight feet of tapeworm were washed out, and it was found to be protruding from a large ragged rupture of the small intestine. The damaged gut was resected and the ends united by a continuous suture. The bowels were moved by enema (an ounce each of glycerine and sulphate of magnesia and a quart of water) to relieve the persistent vomiting, when seventeen feet more of tapeworm came away. The patient made a good recovery.—*New York Medical Journal*.

DIRECT TREATMENT OF PULMONARY CONSUMPTION BY INTERSTITIAL INJECTIONS OF CHLORIDE OF ZINC.—Comby (Paris) has treated three cases of tuberculosis of the apex of the lung by Lannelongue's sclerogenic method. The patients received thirteen interstitial injections of chloride of zinc solution, varying in strength from two to five per cent. The injections were well tolerated, and were not painful if not more than three drops were injected at a time; they were repeated

once or twice a week. The results were favorable, and hold out the hope of annihilating the disease in its incipency when it is confined to the apex, the general condition is good, and the fever moderate or absent.—*Le Bulletin Médicale*.

A SIMPLE TROCAR FOR THORACOCENTESIS.—Stoeren (Christiana, Norway), proposes a simple device for preventing the introduction of air into the pleural cavity in paracentesis of the thorax:

Over the end of an ordinary trocar canula a piece of rubber tubing is slipped, of such a calibre as to fit very tightly. The trocar is then introduced and pushed through the rubber tubing which is held tensely over the end of the canula. The thorax is punctured and the trocar withdrawn, the opening made by the latter in the rubber closing completely by its elasticity. The distal end of the canula is carried to a receptacle and covered with sterilized water. Should the tube become obstructed by flocculi, the stylet is introduced to clear it. Any difficulty in the introduction of the trocar and canula is prevented by tightly stretching the tubing or placing the instrument first in a carbolic solution or in alcohol, which also will serve to sterilize it. Should the tubing become loose it is tied to the canula with a thread. The apparatus is very simple and can be prepared by any one. After all the fluid has been apparently evacuated, the patient is directed to breathe deeply several times, the tube being compressed during each inspiration. In this manner a surprisingly large quantity of residual fluid, amounting at times to over a pint, can be evacuated.—*Norsk Magazin for Lægevidenskaben*.

LUPUS OF THE FACE TREATED BY THIERSCH SKIN GRAFTS.—Oscar Bloch presented a case to the Copenhagen Surgical Society in which a most gratifying result was obtained with lupus of the face by excision of the lupous foci, the incision being carried well into the healthy tissues, the defects being immediately covered by transplantation of skin from the thigh according to the method of Thiersch. Healing was completed in three weeks, the parts being covered with a normal epidermis.—*Hospitals-Tidende*.

[Following the suggestion of Watson Cheyne, *vide* HAHNEMANNIAN MONTHLY, 1891, pp. 673 and 674, we have used this immediate transplantation in all operations resulting in cutaneous raw surfaces, notably excision of the mamma, cicatrices following burns, malignant growths of the face, etc., with uniformly good results. In fact it is our routine practice to have the thigh of the opposite side prepared for the removal of such grafts in all cases where such a defect is expected.—EDS.]

A RAPID METHOD FOR HYSTERECTOMY.—Lanphear (Kansas City) proposes under the above title a combination of the abdominal and vaginal operations which he has practiced with success.

The ovary and tube of one side are drawn up into the abdominal wound and a clamp applied to their outer side, but as near the uterus as possible. A heavy cat-gut ligature is passed through the broad ligament, and an incision made between it and the clamp. The outer side is similarly treated when the uterus and adnexa can be readily drawn out of the wound. The peritonæum is divided transversely and the bladder separated from the uterus by blunt dissection. The vagina is opened on the finger, and the incision extended across the anterior surface of the cervix. The cul-de-sac of Douglass is similarly opened. Guided by a finger in the abdomen, the two sides are clamped close to the uterus, which is then quickly cut away. The peritonæum may be sutured or not, as preferred. The clamps are removed in forty-eight hours. The operation has been performed in all cases calling for hysterectomy, including cervical cancer. It has been completed in twenty-five minutes.—*Annals of Surgery*.

AN AID TO REDUCTION OF LUXATIONS OF THE LOWER JAW.—Roth (London) suggests the following plan to steady the patient's head in reducing dislocations of the lower jaw when an assistant is not at hand: The patient is seated in an ordinary chair and leans forward. The operator also leans forward, stands in front of him with the left foot between the patient's legs and the right to one side, and slightly in advance. The patient is directed to place his forehead against the operator's sternum, when the latter by flexing his head grasps the occiput of the former with his chin. The thumbs, properly protected, are then placed in the patient's mouth, while the fingers grasp the lower edge of the jaw, and the reduction is completed in the usual manner.—*Lancet*.

GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D. AND J. NICHOLAS MITCHELL, M.D.

CHLORIDE OF ZINC FOR CHRONIC VAGINAL CATARRH.—Düvelins, of Berlin, warmly recommends chloride of zinc in .005 to .01 solutions, taking care that the labia are held closely around the nozzle of the irrigator while the fountain is elevated sufficiently high for the water to distend the vaginal walls. He has abandoned the use of chloride of zinc for intra-uterine treatment and uses only weak solutions for erosions of the cervix. He has seen dangerous hæmorrhage follow the separation of the slough two or three days after using a strong solution.—*Centralblatt für Gynäkologie*, No. 46, 1892.

THE PALLIATIVE TREATMENT OF CANCER OF THE CERVIX UTERI.—Morocco is of the opinion that radical treatment should not be employed except in the very earliest stages of the disease.

He has obtained excellent results from the following palliative treatment. He cleanses the surface with cotton and applies powdered tannin every day. The treatment requires great patience and may need to be continued for a year. The ulcer soon appears healthier and remarkable improvement follows.—*Centralblatt für Gynäkologie*, No. 40, p. 799, 1892.

PUERPERAL ECLAMPSIA.—Olshausen found that most of his cases were primiparæ, and especially those older than the average. Twin pregnancy was also a frequent cause. The frequency of eclampsia Olshausen estimates as greater than 5 per cent. of all cases. Thirty per cent. of premature labors, he thinks, are caused by eclampsia. In five cases out of two hundred pregnancy was not interrupted by this complication. It is rare for eclampsia to persist after a brief period of the acute disorder. As prodromal symptoms, were observed headache and, more important, gastric pain, with frequent vomiting. Amaurosis was rarely observed. In three cases an aura was present. Albumin was almost invariably present in the urine. Casts were often found, œdema rarely, and icterus was observed twice. Twenty-five per cent. of the two hundred perished, and post-mortem examinations were obtained in thirty-seven cases. Acute affections of the kidneys were found in twenty-two of these, chronic interstitial nephritis in four. The remainder showed a mixture of acute and chronic diseases. In two cases the kidneys were unchanged. Most fatal cases terminated in four days after the first convulsion, although convulsions occurred as late as the thirtieth or fortieth day after labor. The complications causing death were sepsis and pneumonia, eclamptic patients being especially susceptible to septic poison. Regarding prognosis, it is often favorable where convulsions begin soon after the birth of the child. Frequent convulsions, rise in temperature, small and frequent pulse are signs of a fatal issue. Twenty-eight of the children born at term died. This result is sometimes owing to morphia intoxication. As regards the treatment of eclampsia, Olshausen depends upon morphia, chloral and the use of the forceps. Version is contraindicated, and chloroform should be used only where the convulsions recur regularly. The intoxication theory of eclampsia seems most probable.—*The British Gynecological Journal*, November, 1892.

SOLID OVARIAN TUMORS.—Dr. Bantock's case of fibroma of the ovary occurred in an elderly woman. While Dr. Napier was describing his case, and before he had used the word sarcoma, or even indicated it, he (Dr. Bantock) had come to a correct conclusion from his own experience. He had never seen a solid ovarian tumor in a young subject that was not a sarcoma. He would always regard with great suspicion a solid tumor—not uterine—in a young subject.—*The British Gynecological Journal*, November, 1892.

VAGINAL HYSTERECTOMY IN CANCER OF THE UTERUS.—The preparation of gut for use in the operation is as follows: The best quality of gut is selected in the numbers desirable for use, which, for heavy ligatures, varies from Nos. 4 to 6; for plastic work, from Nos. 2 to 4. For two weeks or longer it is placed in sulphuric ether, and the jar shaken daily once or twice; then it is removed, and for two or three hours wrapped in a dry, sterilized towel, to let the ether evaporate. It is then

put into a watery solution of corrosive sublimate, 1 : 5000, for from eighteen to twenty-four hours, from which it is placed in a jar of absolute alcohol, in which it is boiled in a water-bath for several hours. The paper tied over the jar to cover the gut is pierced at several points with a needle to prevent an explosion. Clamps are used when the parametria are so much infiltrated that the uterus could not be brought down for the application of ligatures. A very strong reason for total rather than partial extirpation is given—the fact that independent nodules of original growth are often found in the body of the uterus. G. Winter relates a case in which the disease seemed limited to the portio, but in which several carcinomatous pelvic glands were found; these he explained by way of infection through the lymphatics. A movable uterus is not always operable, because the bladder may be so involved as to contra-indicate an operation. A fixed uterus invaded by cancer does not contra-indicate operation if the fixation be entirely due to inflammatory products. Extirpation should not be performed unless all diseased tissue can be removed. The patients do not live so long, usually the pain is excruciating, and there is a fetid discharge, and their comfort is not promoted. A thickening of the parametria or of the folds of the peritonæum posteriorly does not contra-indicate hysterectomy if it is caused by inflammatory infiltration. Inflammatory infiltrations are elastic; carcinomatous infiltrations have a peculiar resistance, and are bulky. The operator who has practiced pelvic massage has the advantage here because of his superior touch.

Improved statistics show that out of 474 operations in the large German clinics, there were 40 deaths, showing a percentage of 8.4 direct mortality. In Leipsig the mortality is 8.2 per cent. Dr. Joseph Price's rate of mortality is 5 per cent., the same as Dr. H. T. Byford. In the city of Berlin the percentage of still operable cancer was, in 1883, 26.8 per cent.; in 1890, 46.3 per cent.—H. J. Boldt, M.D., in *Annals of Gynecology and Pædiatry*, November, 1892.

NEW CONTRIBUTIONS OF THE ELECTRICAL TREATMENT, BOTH GALVANIC AND FARADIC, TO DIAGNOSIS IN GYNÆCOLOGY.—The clinical results, very briefly set forth, are the following:

1. Every uterus interrogated galvanically at the dosage of 100 to 150 milliampères, which gives no action, operative or post-operative, and which not only tolerates this dose, but has its dominant symptoms lessened thereby—such tolerant uterus has a practically healthy periphery, and indicates electric treatment, of which the galvanic dosage should not be limited except to fulfill the clinical indications. If there is no inflammation of the tubes, even though there be a simple cyst of the ovary, the same tolerance will be observed.

2. Every uterus which does not support 50 milliampères, or which supports them badly, and where the operative sequelæ are very painful or febrile, is a uterus whose periphery is suspicious, and should not be experimented with except with the greatest moderation and prudence.

3. Every uterus whose initial intolerance is lessened with the number of applications either is a hysterical case or one in which the inflammatory condition is undergoing retrogression or arrest.

4. Every uterus whose intolerance, excessive from the first, develops and increases with the number of *séances* and is accompanied by an elevation of temperature, is one whose periphery is affected by a lesion not appropriate to conservative gynæcological treatment. Here a suspension of galvanic treatment is demanded, and it becomes necessary to proceed to operative interference.—Dr. G. Apostoli in *The Archives of Gynecology*, November, 1892.

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

THE SUBCONJUNCTIVAL APPLICATION OF COCAINE IN EYE OPERATIONS.—Dr. Carl Koller, of New York City, proceeds in the following way to anæsthetize the subconjunctival tissues of the eye: The conjunctiva is first rendered anæsthetic by the instillation of a 4 per cent. solution of cocaine; a speculum is then inserted, a fold of the conjunctiva (over the selected site of operation) is picked up by means of mouse-toothed forceps; the needle of a hypodermic syringe is inserted through

this fold into the subconjunctival tissue as deep as possible, and a few drops of a 2 per cent. solution injected. With a 2 per cent. solution and even a 1 per cent. solution, an entirely satisfactory anæsthesia can be produced if the solution is well distributed over the field of operation.

After the injection the speculum is removed and the eye is closed, so that the artificial œdema of the conjunctiva may be given time to disappear, which it does in about five minutes. The disappearance may be helped by a little rubbing.

The hypodermic syringe used should be sterilized and rinsed in a 2 per cent. carbolic acid solution.—*New York Medical Journal*, January 7, 1893.

REFLEX SPASM OF THE GLOTTIS FOLLOWING DISTENSION OF THE STOMACH.—In India a soldier who had been for a few days without meat, gorged himself with tough, uncooked meat in pieces varying from four to seven inches in length. He then drank much water, and sang for about an hour, when he was affected with occasional pain in the larynx and with cough. Gradually dyspnœa succeeded, which prevented his sleeping. Promptly taken to the hospital, examination showed nothing visible beyond distension of the stomach. The obstruction to breathing seemed to be in the larynx. His speech was whispering and altered in quality. He complained of pain over the hepatic area. Hot fomentations to the larynx and occasional inhalations of chloroform were administered, but their effect was transitory. The spasm prevented him from swallowing an emetic. Blisters were then applied along the course of the vagi, and cupping over his stomach repeatedly performed. In about half an hour the result was well marked, the spasms stopping for a time. Finally an emetic was taken, and about a pound and a half of meat vomited. His symptoms hence improved, though for three days he had a spasmodic laryngeal cough. For want of an instrument no laryngeal examination could be made. The day after the meal hepatitis appeared, but was easily cured. As soon as the laryngeal symptoms abated the patient could swallow freely, so that direct pressure on the larynx by a mass of meat in the œsophagus was out of the question; while the marked effect of the counter-irritation of the vagus seemed to point to the symptoms being due to reflex irritation from the stomach.—*The Lancet*.

THE PRESERVATION OF VISION.—Dr. Webster Fox has formulated the following propositions as an aid to the preservation of vision (*The Sanitarian*, November, 1892): 1. Do not allow light to fall upon the face of a sleeping infant. 2. Do not allow babies to gaze at a bright light. 3. Do not send children to school before the age of ten. 4. Do not allow children to keep their eyes too long on a near object, at any one time. 5. Do not allow them to study much by artificial light. 6. Do not allow them to use books with small type. 7. Do not allow them to read in a railway carriage. 8. Do not allow boys to smoke tobacco, especially cigarettes. 9. Do not necessarily ascribe headaches to indigestion, the eyes may be the exciting cause. 10. Do not allow the itinerant spectacle vender to prescribe glasses.

COCAINE IN EYE DISEASES.—In an article on the "Uses and Abuses of Cocaine" (*Med. and Surg. Reporter*) Dr. Arthur G. Hobbs makes the following statements:

"I desire to emphasize most decidedly one contra-indication to the use of cocaine as a collyrium, and that is that *it should never be used when an abrasion of the cornea exists*; nothing in the form of a collyrium is more deceptive, as it is also most grateful to a denuded corneal surface.

"The cornea is covered with the epithelial layer of the conjunctival mucous membrane only; here no middle layer proper exists whence it can derive its nutrition, hence it quickly loses its vitality when subjected to this local anæsthetic. So also the outer layer of the cornea, receiving its nutrition by imbibition only, seems to be even more susceptible to the destructive effects of cocaine.

"I have seen a number of cases during the last few years (especially since this drug has been introduced into general use) in which the cornea has been greatly damaged by its constant and frequent introduction, for no other purpose than the temporary relief of pain; but unfortunately the relief thus produced proves to be a delusion, and the destruction produced upon the cornea is only masked for the time by the anæsthetic effects.

"I have especially seen these bad results in the cases of physicians who had themselves persisted in its use for the comforting effect to their own eyes, both during the presence of foreign bodies on the cornea and after their removal.

"Cocaine is contra-indicated also in any corneal inflammation, and should not be prescribed beyond the acute stage of any form of conjunctivitis."

MONTHLY RETROSPECT OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D., AND FRANK H. PRITCHARD, M.D.

TREATMENT OF MIGRAINE.—Dr. H. Möser divides this affection into two forms: the spasmodic and the paralytic. In the former the skin of the affected side is cool and pale and the pupil dilated; in the latter the skin is red and hot and the pupil is contracted. In reality these two forms are not so sharply defined and the symptoms run into each other. Its advent is usually ascribed to mental or physical overexertion, gastric disturbances or menstrual irregularities. It may appear at irregular and undefined periods or observe a certain regularity in its appearance. Coffee-drinking is a very frequent cause. One can never hope to cure a case without forcing the patient to give up coffee entirely. If an abuse of coffee be admitted, then one may antidote it with *nux v.*, *ignatia* or *opium*, especially when constipation accompanies the condition. Aconite may also be found to be an antidote.

Belladonna corresponds to the symptom complex, with congestion, more frequently than it will be found to cure. There is great sensitiveness to light and noise, etc., yet *gelsemium*, and especially *sanguinaria* are more useful.

Gelsemium.—Great excitement of the nervous and vascular systems. It is to be preferred to belladonna in women who are inclined to hysteria, very irritable and when the migraine is accompanied by a congestive state. Belladonna to be chosen when there is a narrowed and *gelsemium* dilated pupil.

Glonoine.—Violent cerebral congestion, especially shortly before and during the menses, with changes in the heart and vascular system. If psychic or physical shocks are known to have caused the attacks then glonoine is the better indicated.

Coffea.—The patient is not a coffee-drinker, or better cannot bear coffee. The cause was excessive joy, with over-excitement of all the senses. Used the higher potencies.

Sanguinaria and *iris* are, according to the writer, the most reliable remedies.

Sanguinaria.—The pains usually begin in the morning, commencing in the occiput and running upwards and forwards to settle over the right eye. They are generally very intense, the patient cannot bear the slightest noise and light; she presses her head into the pillow to obtain slight relief. Finally, there is vomiting of food or mucus and bile. The gastric symptoms of *sanguinaria* are more prominent than those of *belladonna*, *gelsemium* or *glonoine*.

Iris.—With this remedy the gastric and intestinal symptoms are still more pronounced, and possibly with association of a hepatic disorder. The pain is especially left-sided; the iris patient is better from moving about; rest and quiet do not relieve him.

Niccolum Sulphuricum.—A remedy rarely mentioned yet one which will surprise one when indicated. The pain is most severe in the forenoon, between 10–11 o'clock, and with such intensity that the patient cries out in anguish. It appears at first upon the left side, then, possibly jumps over upon the right. In the evening the pain disappears.

Asarum, cicuta, cobalt, melilotus, arnica, apis, calc. carb., capsic., natrum mur., platina, sepia, spigelia, etc.

He also advises regulating the patient's diet and the employment of hydropathic measures.—*Homöopathische Monatsblätter*, No. 2, 1893.

CLINICAL EXPERIENCES WITH POTASSIUM PERMANGANATE.—In a most valuable paper on potassium permanganate, Dr. H. F. Ivins recommends the following method of preparing the drug: A few crystals are placed in a little water, the re-

sult being a cherry-red solution. Of this, one teaspoonful represents a dose. Dr. Ivins was led to use the drug on the recommendation of Dr. J. W. Heysinger, who has formulated the following precautions respecting the use of the permanganate: "A wash of water may follow it in the mouth, but under no circumstances must sugar, lemon, fruit or other organic matter be immediately used before, with, or after this medicine when given in solution. Unvitalized organic matter at once destroys and reduces the permanganate to an inert manganate, the oxygen is wasted upon the organic matter, and the whole is useless. But vitalized organic matter is not attacked, as is the case with chromic acid." Dr. Heysinger recommended the permanganate in diphtheria, diphtheritic scarlatina, acute acne, and boils. In the former of these conditions, Dr. Ivins has used the drug but little, though with satisfactory results. In the latter conditions, and in otorrhœa of long standing, particularly if the result of diphtheria or scarlatina, the permanganate has acted well. The remedy seems to be better adapted to these cases if the prostration be great and the discharges very excoriating and thin, in addition to which there are glandular enlargement and eczematous conditions about the scalp. Its keynote then is debility, coupled with some suppurative or threatened suppurative process.—*Southern Journal of Homœopathy*, January, 1893.

PERMANGANATE OF POTASSIUM IN DIPHTHERIA.—In diphtheria, Dr. Ivins's chief clinical indications are marked prostration, great fœtor, sanious flow from the nose, and slight rise of temperature. The pseudo-membrane, upon which it acts with most vigor, is rather thin, yellowish-white, and with the surrounding membrane bathed in discharge having the preceding characteristics. The drug should be given at frequent intervals, and for at least twenty-four hours before discontinuing its use. Those remedies which follow the permanganate well are *arum triphyllum* and *ailanthus*. The prophylactic action of the permanganate appears to the author to offer the greatest proof of its utility in diphtheria.—*Southern Journal of Homœopathy*, January, 1893.

PERMANGANATE OF POTASSIUM IN DISEASES OF THE EYE, EAR AND THROAT.—Dr. Ivins has used the permanganate of potassium in a large number of eye, ear and throat cases, where the chief symptoms were debility, loss of appetite, indigestion, imperfect sleep, and easy fatigued; the patient's endurance being so slight that he is unable to continue his usual vocation, even short walks completely exhausting him.—*Ibid.*

PERMANGANATE OF POTASSIUM IN FURUNCULOUS CONDITIONS.—In furunculous conditions, permanganate of potassium is called for previous to the stage of pus formation, with severe pain and the sensation of heaviness, pressure and heat. If given at this stage, furuncles in the ear are nearly always brought to a speedy termination without suppuration. Here again if a history of eczema or of its present existence is obtainable, the case is more likely to do well, and for mastoid abscesses, acne, and the spring crop of boils, in which we have been taught to look upon *arnica* as the remedy, Dr. Ivins suggests a trial of *kali permanganicum*.—*Ibid.*

REMEDIES FOR MULTIPLE NEURITIS.—*Arnica* will first be thought of in cases arising from traumatism. *Hypericum* has been highly lauded by Hering for the results of injury to nerve structures. The writer's experience does not fully support this recommendation, although he has seen some remarkable effects from it. He inclines to the view that this drug does its best work in the root neuritis due to irritative processes within the spinal canal.

In cases of neuritis due to cold *aconitum* ought to be of service, while *dulcamara*, *rhus*, and other remedies, may be more or less clearly called for by some special quality in the exciting cause, or by some characteristic symptoms.

In cases of multiple neuritis due wholly or in great part to the use of alcohol, the first remedy is *cimicifuga*. The indications for it are the aching pains in the limbs, which the patient likens to a toothache and the use of alcohol in any form as a causal factor. It has been used with the best results when given low, say one drop of the tincture to four ounces of water, in teaspoonful doses repeated every few hours.

For the very severe form of neuritis with paralysis, *arsenicum* 30 will probably be called for during the treatment. The indications will be the well-known symptoms of arsenicum, but at the same time it must not be forgotten that this remedy is one of our best for the effects of alcohol.

China in the 1st, 2d, or 3d dilution has been of great service when the special hyperæsthesia to light touch was pronounced.

In neuritis affecting the lower limbs and especially with pains around the outer aspect of the hips, *berberis* has proven very efficacious, and when the pains are marked in the anterior aspect of the thigh, *pareira brava* 3d seems to have a special influence. Both of these remedies are indicated in neuritis in the regions mentioned even without any bladder symptoms.

Mercurius, or indeed any remedy, may be indicated under special circumstances, and it might be worth while to make dilutions. Of such poisonous gases as CO_2 , ASH_3 , and the extremely toxic CO , as well as of CS_2 , and employ them as remedies in multiple neuritis according to the symptoms as found in the encyclopædia.—Dr. J. T. O'Connor, in the *Medical Century*, March, 1893.

THE GYNÆCOLOGICAL THERAPEUTICS OF CIMICIFUGA.—In many diseases of women *cimicifuga* is one of the most valuable remedies in the pharmacopœia. In amenorrhœa from deficient nerve energy in the ovaries, and when the abnormal nervous influence is directed to other organs, giving rise to hysteria, chorea, etc., *cimicifuga* will restore the functions of the reproductive organs to a normal state. Neuralgias of the ovaries and uterus, with great tenderness and bearing down; menstruation, painful, irregular, or suppressed; heavy headache in front of head, with sore eyeballs and palpitation of the heart, will be relieved by it.

In menorrhagia, when the flow is very profuse and early, dark clotted blood, severe pain in the back, extending through hips and down thighs, the eclectics look upon *cimicifuga* as a panacea, and our own school testifies as to its value. In cases of congestive dysmenorrhœa it is often of the greatest value, but its triumphs have been obtained along the line of rheumatic or neuralgic cases.

Sterility, when not due to extensive ulceration or other structural changes in the uterus, may be cured by *cimicifuga*. Prolapsus uteri is often removed by it, especially when the subject is nervous and melancholic. Ovarian disorders of a nervous rather than of an inflammatory or structural character are relieved by it. In puerperal mania it has been found curative. Irritation of the uterus, such as occurs at the climacteric, and mammary pains of a reflex character occurring during pregnancy with dysmenorrhœa, or at the climacteric and even after confinement are also included within the curative powers of this medicine. Characteristic are the pains flying from side to side, so severe as to double the patient up.—Dr. H. C. Aldrich in the *Medical Century*, February, 1893.

CEDRON IN SUPRA-ORBITAL NEURALGIA.—Dr. Ockford also reports the case of a man, æt. 56, of nervous temperament, who had occasionally very severe attacks of supra-orbital neuralgia. The sight of one eye was destroyed under opium and anodyne. The other eye became involved, the attacks assuming an intermittent character. Cedron 3x relieved and cured promptly.—*North American Journal of Homœopathy*, March, 1893.

[It may well be questioned if this was not a case of glaucoma, and that instead of being a cure, the symptoms are simply in temporary abeyance. A report of the ophthalmoscopic examination and a statement of the duration of the case and the time since the last symptoms are necessary to completeness in this report.—Eds.]

MENTHOL CHLOROFORM IN TOOTHACHE.—The above, in the proportion of five to eight, is highly lauded in toothache. A ball of cotton soaked in the solution is introduced into the tooth cavity.—*Medizinische Neuigkeiten*.

ARSENIC IN CANCER OF THE SKIN.—Lassar, at a meeting of the Berlin Medical Society, presented two cases and reported a third in which carcinoma of the skin had been cured by the use of arsenic. Fowler's solution was used either subcutaneously or internally, without any local treatment.—*Munchener Medizinische Wochenschrift*.

Touton (Weisbaden) reports a similar result by the same treatment in a case of general sarcomatosis of the skin.—*Ibid*.

VERIFICATION OF COLOCYNTHIS.—Mrs. A., aged about forty, consulted me two years ago for the relief of a severe form of sciatic neuralgia of the left leg. She had been well up to about four years before, when she was taken with a very severe pain in the stomach and left ovarian region, the cause of which she could not explain. The pain was so severe at times that she would become delirious and vomit

with great difficulty. Treatment met with but partial success, when suddenly the pain appeared in the left sciatic nerve and continued periodically in that locality for one year. When I saw her first, she had intense drawing, aching pains ending in twitching in the calf of the leg. Cramping pains would run from the hip to the foot and vice versa. Occasionally there would be a throbbing which would invariably end in a drawing pain along the whole length of the limb. Colocynth 3x was prescribed to be taken every one or two hours in water. She was discharged cured in four days, and when I saw her one year afterwards, she said that she had had no more pain.—Dr. H. M. Hobart in the *Medical Era*, January, 1893.

INDICATIONS FOR COLOCYNTH.—The case above reported verifies the provings of colocynth, viz., that it acts oftentimes as profoundly upon the nerve trunks and peripheral nerves as upon the abdominal plexus. The trigeminus is often affected, causing hemicrania and toothache. The nerves of the extremities, and especially those about the hip-joints, are often profoundly affected. In a word, there is abundant proof that the great sphere of colocynth lies among the neuroses, where the pain is especially of a crampy and drawing nature, as found in its provings.—*Ibid.*

CALCAREA CARB. IN CONVULSIONS.—F. K., aged four years and six months. When I was called, the patient was in convulsions. Gelsemium and hygienic measures soon brought relief. A careful review of the history of the case showed calcarea carb. to be the similimum. It was prescribed in the 6x trituration, to be followed by the 100x after a week. The child improved, and in four weeks had had but one spasm, and that one was much less severe. After six weeks' treatment the parents considered the patient cured, and did not report when the medicine was gone. In a few days the second and third spasms brought an urgent call, and the treatment was continued with the best results. The boy did well until his medicine was discontinued six months after the treatment had been commenced. At this time the father of the child was thoroughly convinced that the treatment had stopped the convulsions. During the next six months my directions were carried out and the boy had no more spasms. At the same time his nutrition had greatly improved, and a long list of calcarea symptoms had been removed.

W. M., aged 4 years, was admitted to the asylum, suffering from mal-nutrition. He was nervous and pale and had severe pains in his legs, and was very sensitive to the touch; his abdomen was large; extremities weak, cold, and clammy; he had chronic diarrhoea. As the symptoms of rachitis became unmistakable, he began to have spasms. These he had about once each week. Calcarea carb. 6x was prescribed, and the convulsions became lighter and less frequent. At the same time his general health improved and all rachitic symptoms began to disappear. After several months' treatment he made a perfect recovery.—*Ibid.*

FERRUM PHOS. AND FERRUM MET. IN ENURESIS.—A large percentage of the cases of enuresis, especially among children, aside from the necessary surgical and hygienic treatment, require the help of the indicated remedy to obtain a prompt and permanent cure. If time would permit, I would report in detail cases cured by ferrum phos. 3x where there were few symptoms present, except those that showed a more or less irritable and inflamed bladder, with frequent urging to urinate. Ferrum met. 30, or higher, is indicated where the enuresis is diurnal, and worse when the patient assumes the upright position. General ferrum symptoms often help in making the prescription.—*Ibid.*

HYOSCYAMUS.—B. F., aged 16 years, light complexion, nervous temperament. While attending school he had an attack of spasm of the diaphragm. Different old-school physicians were consulted, with no relief for the distressing symptoms. He was unfitted for school-work, and in two weeks returned home. At this time I was consulted. The parents were in great alarm and the patient was equally apprehensive. Hyoscyamus 3x was prescribed every two hours, with immediate benefit. After the second day the remedy was given at long intervals, and in ten days he returned to his school as well as usual.—*Ibid.*

SULPHUR IN AMENORRHOEA.—Miss B., aged 22 years, had hitherto enjoyed pretty good health. At the time I was consulted she made no complaint except that she was suffering from amenorrhoea. She had no pain or headache. Still the menses would not make their appearance for two or three months. At one time she had gone six months. I prescribed sulphur 200, one drop four times a day.

The next day the menses appeared, and the medicine was continued twice a day. She was directed to take the medicine at the next month's period if the menses did not appear. Similar cases are frequently met in practice where sulphur is the remedy.

Sulphur is indicated in this class of cases of late or scanty menstruation by constipation and distended abdomen; by the flow stopping at once after continuing only two or three days; by congestive headache and cold feet; weight on the top of the head; burning heat in the hands and soles of the feet; bearing down, with feeling of weakness. The high potencies usually act best in these cases.—*Ibid.*

PENTHORUM SEDOIDES is the remedy for spring colds with a stuffing up of the nostrils and cold in the head, with profuse nasal secretion; in other words, coryza, with fulness of mucous membrane, abundant secretion, spongy gums and the conditions so commonly called catarrh among the laity. Internally, it should be given in doses of ten drops to four ounces of water, teaspoonful every two hours, and also used as a spray diluted with water.—*Medical Current*, November, 1892.

VERATRUM VIRIDE.—This is a remedy allied to all congestive conditions, and, in my opinion, in nearly every case in which it is indicated this will be found to be a starting-point, and other manifestations are but the result of that congestion. The picture of the drug is about like this:

There is a high temperature, thermometer ranges from 102.5° to 105°. Pulse attains a rate of from 90 to 120 per minute. The pulse is full, hard and so incompressible that it raises your finger at every beat. The face is flushed a dark red, almost purple, or occasionally it is pale and sunken. The tongue is large and flabby, covered with a thick, dirty, whitish-brown coating, or the edges are red and dry and through the centre runs a dry brownish streak. The breath has a peculiar pungent odor. The sensorium is so dulled that you are in doubt at times whether you are heard, or, if the patient hears you, if he comprehends. If he does talk, he is very apt to complain of a dull, heavy feeling over the head, but much worse in the region of the occiput. As a usual thing, however, the patient does not complain of any pain. There may be great soreness in all the muscular tissues. To me these are characteristic symptoms, and whenever I find this group I exhibit veratrum viride with confidence, and the picture is so plain that it need not be mistaken.

I have found it *often* indicated in nearly all kinds of diseases from the typhoid and puerperal fevers to the very prevalent la grippe of 1890-91.—Dr. S. W. Rutledge, in the *Medical Current*, December, 1893.

MOSCHUS IN CHOREA.—This is a remedy from whose use I have had most happy results. I would urge upon the members of the profession, should they ever have an aggravated case of chorea, to think of it and give it a thorough study. Its pathogenesis I need not give, as any good work on materia medica will present the array of symptoms better than I can. I will say that I have had within the past year four cases in a very aggravated form, all with almost exactly the same symptoms. The especial features I now recall were excessive activity of the upper extremities, mouth, eyelids and head. In each of these four cases the apparently indicated remedy had failed. The results from moschus were prompt and satisfactory.—*Ibid.*

HOMCEOPATHIC THERAPEUTICS OF XANTHOXYLLUM.—Xanthoxylum is a minor drug, but is infrequently indicated and used, although fairly well proven. The various pains experienced by the provers in joints and muscles, definite and recurring, would point to the probable efficacy of the drug in rheumatism, its ancient usage. It has *cured* neuralgia of the facial nerves, also *sciatica*, worse in hot weather, especially of the anterior crural nerve (after *Gnaphalium*). Marked hoarseness, dyspnoea, persistent cough, etc., in several provers makes reasonable two cures on record, "cough" and "incipient phthisis."

Female Sexual Organs.—The effects upon the five female provers were very marked, shown in severe pains in the head, flash-like, "as if top of head were about to be taken off," leucorrhœa in gushes, severe ovarian pain and *dreadful distress* at menstrual period, neuralgic pains down genito-crural nerves, *early* and *profuse menstruation*, etc.

Usage—Amenorrhœa, with any above conditions, nausea at the sight of food, mental depression, etc.

Dysmenorrhœa, with the above symptoms; both head and local pains left-sided

(making the drug very similar to *Actea rac.* and *Caulophyllum* in female complaints); in spare, delicate, nervous women. (Six cures on record.)

After-pains.—Dr. W. E. Leonard, in the *Medical Current*, January, 1893.

COCAINE IN TUBERCULAR MENINGITIS.—Dr. C. R. Crosby reports the case of a boy, aged 12 years, with tubercular meningitis. The usually indicated remedies had been administered without result. An article in an allopathic journal reported a case of cocaine poisoning coming to hand, a comparison showed that it had all the symptoms of his patient. One symptom in particular, which would not yield to any remedy, was dilatation of the pupils and non-reaction to light. Cocaine, two drops of a 2 per cent. solution was put in a half-glass of water, and given in two teaspoonful doses every two hours during the night. The next morning the delirium was very much modified; discontinued cocaine till next night, and then repeated it. From that time convalescence began, and at this writing the patient is about the house and improving rapidly. The leading indications are herewith presented: Temperature, 104.5; respiration, 36; pupils dilated: would drop suddenly into a heavy sleep for about twenty minutes, then wakes with increased delirium; then great excitement; laughs, cries, gesticulates, talks incessantly, pays no attention to questions, changes position constantly; dizzy, staggers like one intoxicated, then exerts twice the natural strength; urine natural in quantity; skin cool, sometimes very dry and sometimes drenched with profuse sweat; face pale, with an occasional besotted look. An upright position seemed to be preferred by the patient. All the pain complained of was in the back of the head.—*Medical Era*, January, 1893.

ACTION OF TARTAR EMETIC ON THE AIR-PASSAGES.—Under antimonium crudum there is a thin and squeaking note of hoarseness, worse in hot rooms; under tartar emetic, a rougher and looser hoarseness, worse in the morning after coughing and from talking. Antimonium crudum is characterized by more spasm of the air-tubes than tartar emetic, and in this respect is similar to ipecac. The cough, moreover, of antimonium crudum is drier and more spasmodic than tartar emetic, similar to ipecac, and under antimonium crudum the cough is worse when going into warm air, after cold air, the reverse of tartar emetic. The respiratory symptoms, as a whole, under all three remedies, I believe are largely dependent upon and are altered by the dose, its repetition and its continuance. Clinically, I have found antimonium crudum answers best in the lower dilutions for dryness and spasm of the air-tubes, and tartar emetic and ipecac, in dilutions from 6x up to 12x; while tartar emetic, in dilutions from 1x to 3x, has answered best when there has been much secretion and rattling of mucus with less spasm but with more congestion of the respiratory organs.—Dr. A. C. Clifton, in the *Monthly Homœopathic Review*, March, 1893.

APIS MELLIFICA IN RELATION TO THE HEAD.—Besides the recognized heat and congestion, throbbing, shooting and distensive pains, relieved by pressure and aggravated by motion, the vertigo worse when lying and closing the eyes, all of which symptoms I have frequently verified. There is a symptom very similar to the one under helleborus, which I have several times cured by that remedy, and have also greatly relieved by apis, viz, a dull, heavy sensation in the occiput as from a blow, extending to the nape of the neck, and relieved by pressure, accompanied with sexual excitement and desire, differing in the latter respect from helleborus, where the very opposite condition has been very marked, mainly in men of middle age who have largely indulged in the use of tobacco, spirituous liquors and venery.—*Ibid.*

APIS IN AFFECTIONS OF THE EYES.—I have found this remedy highly curative in catarrhal and strumous ophthalmia and interstitial keratitis, especially when these cases are characterized by anæmia and general debility. While prescribing apis, I have found the hypophosphite of lime in the form of a syrup twice a day after meals very helpful.—*Ibid.*

ANTIMONIUM CRUDUM IN ITS RELATION TO THE MIND, THE SENSORIUM AND THE HEAD.—A spirit of crossness and contradictiveness; whatever is done for the patient fails to give satisfaction. Vertigo and staggering when walking, feeling as if intoxicated, with full sensation in the head, and nausea, all increased by going up stairs or by looking fixedly at an object. These symptoms, apart from and sometimes with the gastric symptoms about to be named, I have repeatedly cured with this medicine.—*Ibid.*

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DIURETICS IN THE TREATMENT OF URÆMIA.

BY CLIFFORD MITCHELL, M.D., CHICAGO, ILL.

It will hardly be denied that uræmic accidents are most common in those forms of Bright's disease in which we habitually find light-colored urine.

Now, in such cases, the urine is not usually below normal in 24 hours' quantity; more often it is in excess of normal; sometimes twice the normal figure. Nevertheless, the quantity of urea is seldom as great as normal per 24 hours even when the patient is not restricted in diet. More often the urea per 24 hours is sub-normal; frequently half normal; sometimes barely one-third normal.

In other words, there is often practically no relation between the amount of urine per 24 hours and the amount of urea per 24 hours. I will instance four or five cases:

CASE 1. Bright's disease in a young girl. Patient, during eighteen months' observation, passed light-colored urine, loaded with albumin, and containing numerous granular and fatty casts. Was dropsical at times; but dropsy was not great at any time. Finally, death from uræmic convulsions, though there was an abundance of pale urine voided almost to the very hour of death.

CASES 2 and 3. Reported by me in the *Medical Era* for January, 1893. Diuretin used to increase the urinary water. In the first

case the volume of urinary water per 24 hours was increased six-fold, but the urea per 24 hours decreased one-half.

CASE 4. Female patient on non-nitrogenous diet. Patient elderly, thin, nervous temperament, with history of pyuria of several years' standing. Analyses covered a period of several months.

	1st Analysis.	2d.	3d.	4th.	5th.
Volume of urine pr. 24 hours, in c.c.	1600	1225	1860	1975	1775
Volume pr. 24 hours, in fluid ounces	53	41	62	66	60
Day urine, in cubic centimetres.....	.....	650 c. c.	1000 c.c.	1150 c.c.	1100 c.c.
Night urine, " " .....	.....	575 "	860 "	825 "	675 "
Ratio of day to night.....	.....	1 to 1	1½ to 1	1½ to 1	1½ to 1
Urea, grammes per litre.....	4	5	2	7½	4½
Urea, grains per fluid ounce.....	2	2½	1	3½	2
Urea, grammes per 24 hours.....	6	6	3½	15	8
Urea, grains per 24 hours.....	95	95	50	235	125
Phosphoric acid, grammes pr. litre	0.75	0.9	0.65	0.8	0.6
Phosphoric acid, grains per flu. oz.	0.3	0.5	0.30	0.4	0.3
Phosphoric acid, grammes pr. 24 h.	1.2	1.1	1.21	1.58	1.06
Phosphoric acid, grains pr. 24 h'rs	18	18	18	25	16
Total solids, by Trapp's coef., grms.	29	29	29	45	35
Ratio of urea to phosphoric acid.....	5 to 1	6 to 1	3 to 1	9 to 1	7 to 1
Specific gravity.....	1008	1012	1008	1012	1010
Reaction.....	Acid	Acid	Neutral	Acid	Acid
Albumin	Trace	Trace	Trace	Trace	Trace
Sediment.....	{ Pus and round cells.	{ Pus and 1 or 2 colorless casts.	{ Pus. Bladder round epithel'a	{ Pus. round & scaly epithelia.	{ Pus and some epithel'a

A study of the analyses will show the following: First, urine of remarkably poor quality as regards urea and phosphoric acid, seen in the first three analyses. Second, a temporary improvement shown in the fourth analysis, then a retrogression as shown in the fifth.

The cause of the increased volume per 24 hours, as per the third, fourth and fifth analysis, was the ingestion of large quantities of fluids for the purpose of eliminating more urea, if possible. At the time of the fourth analysis, it seemed as if the diuresis was indeed of value in promoting the elimination of urea. Yet with but little

less urine, at the time of the fifth analysis the urea diminished about one-half, both relatively and absolutely, though the diet was practically the same.

It was then decided to maintain the same diet and reduce the volume of liquids ingested. Here is what happened: On the sixth analysis, with but 940 c.c. of urine per 24 hours (31 fl. oz.), there were 13 grammes of urea per 24 hours (200 grains) and $1\frac{1}{2}$ grammes of phosphoric acid (25 grains). In other words, with half the urine there was nearly twice the urea of the previous (fifth) analysis. The total solids rose to 38 grammes, which was but seven grammes less than when nearly 2000 c.c. of urine were voided (fourth analysis).

Under the same conditions a seventh analysis was made with practically the same results, as in the sixth.

In other words, this patient did about as well, so far as elimination of urea was concerned, when voiding 1000 c.c. of urine per 24 hours, as when voiding 2000 c.c.

Doubling the volume of the urine then did not by any means double the quantity of urea and solids; only once did it increase at all the quantity of urea and solids, and then not enough to warrant pushing the administration of liquids with vigor. Moreover, at the time of the fourth analysis, there was an improvement in the general condition of the patient, which, to my mind, accounts for the increase in urea. I believe that nearly if not all the urea voided would have been observed in connection with a normal flow of urine. When the patient's general condition was bad, the administration of fluids was hopelessly inefficacious in promoting the elimination of urea. There is, then, practically nothing which goes to show that this patient gained anything, so far urea is concerned, by voiding over 1000 c.c. of urine in 24 hours.

CASE 5. Elderly male patient with rheumatism. Diet in the main non-nitrogenous. Quantity of fluid administered precisely the same by measurement daily. Patient taking 15 grains of piperazine daily, *after* the first analysis:

These figures are instructive, inasmuch as they show the elimination of urea to be practically the same per 24 hours during a period of three months over which the analysis extended.

At the time of the second analysis, which was made a fortnight after the first, the volume of urine was three times that at the time of the first analysis, and yet the quantity of urea per 24 hours was practically the same as that at the time of the first analysis.

Suppose, now, we had decided to give this patient sufficient fluid

	1st Analysis.	2d Analysis.	3d Analysis.	4th Analysis.	5th Analysis.
Volume of urine pr. 24 hours, in c.c.	600	1800	1575	900	675
“ “ “ in fl.oz.	20	60	53	30	22
Day urine, in c.c.....	260	950	700	350	250
Night “ “	340	850	875	550	425
Ratio of day to night.....	0.75 to 1	1 to 1	0.8 to 1	0.6 to 1	0.6 to 1
Urea, grammes per litre.....	20	8	8½	13	20
Urea, grains per fluid oz.....	9½	3½	4	6	9½
Urea, grammes per 24 hours.....	12	14	13	12	13½
Urea, grains per 24 hours	185	220	200	185	210
Phosphoric acid, grammes per litre	2	1	1.05	1.36	1.9
Phosphoric acid, grains per flu. oz.	1	0.5	0.5	0.6	0.8
Phosphr. acid, grammes per 24 hrs.	1.20	1.8	1.65	1.2	1.28
Phosphoric acid, grains per 24 hrs.	19	27	25	20	20
Total solids (Trapp), grammes.....	25	.....	38	29	23
Ratio of urea to phosphoric acid.....	10 to 1	8 to 1	8 to 1	10 to 1	10 to 1
Specific gravity.....	1021	.....	1012	1016	1017
Reaction.....	Acid	Acid	Acid	Acid	Acid
Albumin	Trace	Faint trace	Trace	Plain trace	Trace
Sediment..... {	A few casts.	A few pale casts.	A few casts.	.....	A few casts.

to cause him to void his 500 grains of urea a day. Now, if he gained but 35 grains of urea per 24 hours by tripling the volume of urine per 24 hours, it would have been necessary to increase his urine 24-fold, mathematically speaking, in order to bring about elimination of 500 grains of urea. In other words, the curtain would have had to rise on the physician with his hand on the pump, like Dixey in Adonis, and the pump-handle could not have been allowed rest until 30 pints of water had been pumped into the unfortunate patient! So much for mathematics in medicine. Practically, no quantity of water possible for a man to take, could have brought this patient's elimination of urea up to normal.

The bearing of these experiments and figures on therapeutics seems to me to be as follows.

In some cases of deficiency in ureal elimination, nothing is gained by use of diuretics, including water. Such cases are usually those

in which light-colored urine is habitually voided. The physician should cause the urine to be collected for 24 hours while the patient is on ordinary diet, both as regards solids and liquids. If the urine is found to be light-colored and not below normal in volume, the administration of diuretics should be followed by repeated analyses to see whether anything is being accomplished by increasing the volume of urine. Particularly should this be done when no improvement in the general condition of the patient is observed. Deluging such patients, especially with mineral waters, will often do no good and, perhaps, even harm. Still more is this true in regard to the use of powerful diuretic drugs.

CLINICAL ASIATIC CHOLERA.

BY M. W. VAN DENBURG, A.M., M.D., FORT EDWARD, N. Y.

(Extracts from the foot-notes of a forthcoming *Materia Medica*).

Aconite.—Twelve cases recovered under this remedy alone, given in drop-doses of the tincture. When collapse comes on very rapidly, with little or no premonitory illness, * and unattended by copious evacuations, aconite is indicated. * The great rapidity of the onset calls for this drug (see camph.). (Dr. Cramoisy, quoted by Hughes).

Arsenicum alb.—Arsenic is given the chief place for the treatment of cholera when the time for arresting it by camphor is past. I believe this is the general experience of homœopathists. (Hughes).

Camphora.—Should be given in the first stage with the rapidly sinking strength; great coldness and anxiety before the purging and cramps set in. It should be administered by the mouth, by friction of the surface, by clyster and by inhalation, and should be persevered in. (Hughes).

Cuprum.—For the cramping it is unquestionably the best remedy; and, I may add, for the vomiting, also; it accomplishes much by keeping the stomach quiet and enabling to introduce and retain other medicines, stimulants or nourishment. (Proctor, quoted by Hughes).

Phosphorus.—Will be found very useful in cholera to check the drain of brownish fluid from the bowels, which sometimes continues after the other symptoms have subsided. (Proctor, quoted by Hughes).

Secale.—Persistent constriction of the arteries is certainly present in cholera. I have great faith in *secale* in the worst varieties of the disease, especially when occurring in women. (Russell, quoted by Hughes).

Veratrum alb.—This is to be trusted more in cases of violent vomiting and purging together with the other prominent symptoms, * but which are destitute of the * essential physiognomy of the disease. Such cases pass for cholera and are curable, but they differ from the fatal cases in the outset. The sudden and deadly collapse of the latter indicates arsenic. (Russell, quoted by Hughes).

(Farrington thus treats of cholera remedies):

Arsenicum alb.—Profuse, offensive, watery stools, which are very exhausting (see *verat. alb.*); (*ars. alb.* lacks the tingling which almost always characterizes the *secale* case); (the restlessness of the *verat. alb.* is not so marked as in *ars.*, while the cold sweat on the forehead is much more prominent); the patient wants to be wrapped up warmly; (*secale* wants to be uncovered, as does *camph.*, also); there is burning thirst, and the patient feels on fire inside; the anguish, fear and restlessness of *ars.* is present in a marked degree.

Camphora.—The system is overwhelmed by the suddenness of the attack or the violence of the poison; intense prostration is present before either the vomiting or the diarrhoea; the body is as cold as ice; the voice is husky and squeaking; tincture of camphor, a few drops in water, a teaspoonful every fifteen minutes until reaction sets in, when some other remedy will be indicated. *Camph.* is better suited than *verat. alb.* when the discharges are scanty and the nausea marked.

Carbo veg.—In collapse, when the patient lies quiet, too weak to move, with possibly passive hæmorrhage from the nose, and may be from the bowels, also; the body cold, * especially from the feet to the knees, the pulse rapid and thread-like, the breath cold, then this remedy may remove the alarming symptoms and save some of these desperate cases.

Colchicum.—The face is hippocratic, the lower jaw dropped from extreme exhaustion; the involuntary stools contain white flakes and shreds; there is spasm of the sphincter and constant urging; the pulse is feeble, the respiration slow; absolute disgust for food, even the sight of it.

Croton tig.—Nausea, with faintness and loss of sight; colic better from warm drinks; * the stool returns with every effort to eat or drink, and rushes out as if shot from a hydrant.

Cuprum.—Intense coldness of the body (camph.); blueness of the surface (secale, camph.); * the muscles of the calves and thighs cramp into knots; great distress of the epigastrium; * intense dyspnœa; he cannot bear even a handkerchief to approach the face. (Camph. has not so much cramping; secale not so much dyspnœa).

Euphorbia corol.—Vomiting and purging, with cold sweat all over the body; * the patient wants to die. (Fears to die, ac., ars. alb.).

Hydrocyanic ac.—Marked and sudden collapse, with cessation of all discharges, vomiting and diarrhœa; coldness and blueness of the surface; great distress about the heart; irregular, gasping respiration. (Suffocation, cupr.).

Jatropha cur.—Great prostration simultaneous with vomiting and purging; the vomited matter looks like rice-water or the white of an egg (colch.); there is coldness of the body and cramps in the legs.

Lachesis.—Vomiting renewed by the least motion; the nausea is attended by a great flow of saliva in the mouth (colch.); prostration attends with coma; the abdomen is hot, the extremities cold (colch.); (colchicum has more tympany, and is not sensitive below the epigastrium). Lach. has also very offensive stools, intolerance of the slightest touch, and constant urging, but not to stool, much worse after sleep.

Secale.—Stools profuse, offensive, watery and very exhausting (verat. alb.); surface cold and blue, but the patient wants to be uncovered (camph.); formication and tingling are usually present in secale cases; not so restless as arsenic, nor with the cold sweat of veratrum.

Tabacum.—The face is pale and livid; he does not care whether he lives or dies; (wants to die, euphorb.; fears to die, ac., ars. alb.); cold extremities, covered with cold, clammy sweat; extreme relaxation, feeble pulse, tightness across chest, suffocative breathing, extreme nausea, vomiting, sudden slimy stool, or both vomiting and stool suppressed.

Veratrum alb.—Vomiting and purging at the same time (ars. alb.); profuse rice-water stools (colch., jatroph.), with colic pain in the abdomen, cramps in the abdomen and calves (colch.); the stool is attended and followed by extreme prostration, cold sweat all over, * especially profuse on the forehead; it will be of little use to give this remedy unless pain is present; the surface is blue and very cold (camph., colch., cup., sec., ars. alb.); the thirst is very intense, and there is great restlessness (ars. alb.).

(Burt suggests the following groups of remedies):

I. *Ac. camph.*, *ars. alb.*, *verat. alb.*, *cuprum*, *phos.*, *secale*, *rh. t.*, *bry.*, *ip. ec.*, *cincho.*, *atropia*.

II. *Phos. ac.*, *coloc.*, *bell.*, *nux v.*, *pod.*, *lach.*, *bapt.*, *strych.*, *arg. n.*, *mur. ac.*, *phos.*

III. *Carbo veg.*, *crot. tig.*, *canth.*, *elater.*, *hydroc. ac.*, *nicotine*, *amyl. nit.*, *merc.*, *ammon. brom.*, *puls.*, *sul.*, *zinc.*, *ferr.*, *op.*, *verat. vir.*, *stra.*, *chloroform*, *chloral*, *ether*.

Adjuvants (Burt) :

Hot fomentations, spinal ice-bag for cramps.

Sinapisms to stomach and between the shoulders.

Friction with hot towels, dry heat to the feet.

Spongio-piline sprinkled with cajuput oil, and applied to the abdomen.

Clysters of starch and opium.

Venous injection of saline fluids or milk.

Hypodermics of ether, chloral, or nitro-glycerine.

Collodion spread over the abdomen has cured many cases at once.

Keep the recumbent posture.

Diet: No solid food until secretions of bile and urine are established.

Milk, animal broths, ice-water, ice ad libitum, soda-water (Burt).

Probably egg albumin beaten to a foam and mixed with water or ice will be found well adapted to cases requiring the lightest diet.
—[Ed.]

CLUB FOOT, AND ITS RATIONAL TREATMENT.

BY EDWARD BLAKE, M.D., LONDON, ENG.

MANY protests have been uttered against the deplorable routine surgical treatment of Talipes. To those let me add one more vehement denunciation of the atrocious practice of promiscuous tenotomy. It is, alas! too true, that any mischievous person can cut a tendon, but a very wise man cannot induce the divided ends to unite once more, should the operation, unfortunately, prove a failure. I am told that even the section of the rectus oculi for strabismus is not necessary; that mechanical contrivances answer even better.

Acute Poliomyelitis—29th August, 1887.—R. D. I., aged nine, was a little delicate boy born at Lisbon, in Portugal, of English

parents. Father is said to be prone to "spasms of the heart," whatever that may mean. Mother is of rather turbid intellect, and has been "weak-chested" for years. Has recently lost a sister, dying of insanity at twenty-one. Another sister, aged eighteen, is certainly not brilliant in brain power. With this nice neurotic history, this poor little fellow began his chequered career in the pathological line by catching a rash (? scabies) from his nurse in infancy. Had "brain fever," with convulsions, at two years; was vaccinated after this attack. Used to vomit in his childhood, and had a habit of wetting the bed. Was living at Valencia, in Spain, at the age of three. One night he was put to bed quite well. The window above his bed, usually shut was, by omission, left open. In the morning he could not stand. It was found that the right knee was firmly flexed on the abdomen, evidently through acute paralysis of the extensors of the hip. The aid of a local practitioner was sought. He gave it as his opinion that something was the matter with the knee! and added that nothing could be done. Thus we may view with admiration his honesty, even if we cannot repress a smile at his primitive pathology. A few months passed away in masterly inactivity. The heel slowly descended, and the boy gradually began to walk again. First on his toes and then afterwards on his heel. He steadily improved until June, 1887, when it was found that the right foot was slowly flattening. In other words, the flexor longus pollicis and the flexor brevis digitorum were giving way. He was now an example of so-called "calcaneo-varus." That is to say, he planted on the ground the os calcis and the fifth metatarsal bone. The foot was flexed, adducted and shortened, and he was brought to England for advice. He was taken first to a gentleman on the staff of the — hospital, who at once said it was needful he should cut a tendon in the sole. When asked if this would improve the power of using the foot, he loftily replied that he had nothing to do with the paralysis, *that* was the domain of the physician! The mother of the boy-patient, not feeling satisfied, next sought the advice of the author of a well-known work on "orthopædic surgery." Unfortunately, the second surgeon proved to be more sanguinary than the former adviser, for he explained that he would not be contented until he had severed two tendons, one in the heel and one in the sole! Had the advice of these good men been followed, what would have resulted? A symmetrical foot, certainly, might have been secured, but with no power of lateral movement, no power of extension, and the boy would have been lamed for life. As a mat-

ter of fact, three applications of the continuous current restored the foot to its natural position, and the lad walked with ease and comfort.

It is, unfortunately, a very troublesome process to galvanize properly; it is tedious, and it often fails. On the other hand, to divide a tendon requires little skill. It is done in a few minutes, and there is a kind of *éclat* about the matter! We can all remember the time when all distortions were viewed as being the result of spasm of the more powerful muscle. The result of a far wider acquaintance with the history of centric nerve lesions now shows that "spasm" is rarely present. The distortion is due to inaction of the weaker paretic extensors rather than to too much action of the flexors.

The case under our consideration is a good example of this curious change in our present pathologic views. We all know that the two longer peronei are amongst the last muscles to be developed in the human body. The dancing-master can tell us the pain and sorrow that this fact is to him. We are all familiar with the inturned feet of childhood, leading often to a curious waddling gait, from the same physiologic fact.

Next day, 30th August, I applied the continuous current for twenty-five minutes to the right leg, the direction of the current being reversed every four minutes. One electrode was placed between the scapulæ, one over the point where the right musculocutaneous branch of the external popliteal nerve enters the peroneus longus muscle, and a current of 1.5 milliampères was employed. There was a marked improvement after the first *séance*, and on repeating this process three times, the right foot was planted firmly on the floor. From failure of the flexor of the great toe, that digit still pointed upwards on both sides. This went down in a few days after applying a mixed current of faradization and galvanism to the posterior tibial nerve.

I may here give a note of warning that the current must, especially in the case of children, be slowly augmented and the effect carefully watched. For, on September 13th, a current of only five milliampères caused a sharp vesication of the skin. Had this occurred on the face there would have been serious disfigurement. There were a few general symptoms present. Irritable, quick temper. Left external rectus oculi has not acted for three years (paresis of 6th cranial), clonus of orbicularis oculi, levator palpebræ, levator anguli oris, and of zygomatici of both sides, all supplied by the facial or

portio dura of the 7th cranial labu. sup. Discharge of mucus from left ear. Fitful vomiting formerly. Penis red and raw. Copious phosphates in urine. Slight cough. Marked thirst. For these symptoms I prescribed arsenic 30, and that is the only remedy the boy had.

CHOLERA REPERTORY.

BY EDUARDO FORNIAS, M.D., PHILADELPHIA.

(A Repertory to Supplement a Paper on Cholera Asiatica Appearing in the HAHNEMANNIAN MONTHLY for October, 1892.)

The principal remedies for EPIDEMIC CHOLERA are: (1) Ars., camph., carb. v., cupr., sec., sulph., verat. alb., (2) acon., bell., bryo., canth., cham., cicut., coloc., crot. tig., ferr., hydr. ac., hyos., jatr., ipec., lauroc., merc., nico., opi., phos. ac., phos., rhus., tabac., tart. emet.

PREMONITIONS.

ABDOMINAL TENDERNESS: Acon., ars., bryo., canth., cham., chin., colch., coloc., crot. tig., cupr., ferr., hydr. ac., hyos., ipec., iris, merc. c., nux v., phos. ac., phos., podo., puls., sulph., verat.—
*IN EPIGASTRIUM: hyos.

ANXIETY: Acon., ars., camph., verat. alb.

CHILLINESS: (1) Ars., camph., sec., verat., (2) acon., bryo., canth., cham., chin., colch., cupr., ferr., gran., ign., merc., nux v., phos., phos. ac., puls., rhus., sulph.

CRAMPS IN THE STOMACH: Carb. v., cham., cocc., cupr., nux v., phos., sulph., tabac.

DEBILITY: Chin., phos. ac.

DEPRESSION: (1) Chin., sulph., (2) ars., bryo., calc. c., colch., coloc., cupr., hydr. ac., iris, merc., phos. ac., podo., verat.

DIARRHŒA: (1) Ars., chin., ferr., ipec., jatr., phos., phos. ac., podo., puls., sulph., verat., (2) cham., colch., coloc., crot. tig., elat., gamb., grat., mag. c., merc., rhus.—*BILIOUS: aloë, cham., chin., coloc., dios., ipec., iris, merc., podo., puls., sulph.; OLIVE GREEN: elat.—*CHANGEABLE: cham., chin., colch., dulc., puls., sulph.; MORE AND MORE WATERY every time: chin.—*FECAL: cham.,

* Words after the asterisk correspond to the heading of the respective sections.

chin., coloc., ferr., gamb., merc., phos. ac., podo., puls., rhod., rhus., sulph.—*FORCIBLE (*gushing*): crot. tig., jatr., gamb., phos.; OF GREEN FROTHY WATER: elat., grat., mag. carb.—FROTHY: chin., coloc., crot. tig., elat., gamb., grat., mag. c., raph., rheum., sulph.—*PAINFUL (*colic, etc.*): cham., colch., coloc., crot. tig., elat., gamb., jatr., ipec., iris, merc., phos., puls., verat.; WITH TENESMUS: ipec., merc., nux v., sulph.—*PAINLESS: chin., colch., ferr., hyos., phos. ac., podo., sulph.; DEBILITATING: chin., ferr., phos., verat.; NON-DEBILITATING: phos. ac.—*SEROUS (*watery*): apis, ars., cham., chin., colch., crot. tig., ferr., ipec., iod., jalap., jatr., petrol., phos. phos. ac., puls., sec., sulph., verat.; WITH RUMBLING: chin., ferr., gamb., grat., jatr., phos., phos. ac., podo., puls., sec., verat.—*LIKE FERMENTED MOLASSES: ipec.—*LIKE RICE-WATER: camph., cupr., ferr., ipec., jatr., phos., phos. ac., sec., verat.; WITH GREAT WEAKNESS and burning thirst: ars.—*LIKE WHEY: jatr., jod., phos. ac., sec.; FORCIBLE AND PROFUSE; cupr., jatr.—*WITH COLD FEELING IN ABDOMEN: grat., nico.—*WITH PAIN IN THE ABDOMEN: ars., cham., colch., coloc., dios., ipec., iris, laur., merc., phos., sulph., verat.—*WITH ANOREXIA: ars., cham., chin., ferr., ipec., phos. ac., podo., puls., rhus, sulph.—*WITH APATHY: camph., phos. ac.—*WITH CRAMPS: cupr., jatr., sulph.—*WITH EPIGASTRIC SINKING: podo.—*WITH FEAR OF DEATH: ars., camph., verat.—*WITH LOSS OF FORCES: ars., chin., colch., ferr., phos., sec., verat.—*WITH NAUSEA (1): ipec., phos., sulph., tabac., tart. emet., verat. (2) arg. n., colch., coloc., crot. tig., iris, jalap, podo, rhus; AND RETCHING: coloc., crot. tig., podo., sec., tart. emet.—*WITH RELIEF AFTER STOOL: gamb.—*WITH PASTY TONGUE: phos. ac.; WHITE: ant. c., puls.—*WITH SHUDDERING: camph., canth., merc., puls., sulph.—*WITH VOMITING (1): ars., cupr., jatr., ipec., iris, phos., sec., sulph., tart. emet., verat. (2), acon., cic., cocc., coloc., dios., elat., ferr., gamb., iod., jalap., petrol.; BILIOUS: acon., ars., chin., coloc., cupr., dig., ipec., iris, jatr., podo., puls., sec., verat.; MUCOUS: acon., dig., dulc., euphorb., ipec., puls., sec.; FROTHY: podo., tart. emet.—*IN THE MORNING: bryo., iris, nat. s., phos., phos. ac., podo., sulph; EARLY DRIVING OUT OF BED: podo., sulph.—*AT NIGHT: ars., chin., ferr., merc., puls., rhus, sulph., verat.—*AFTER EATING FRUIT: ars., chin., coloc., puls.—*AFTER DRINKING IMPURE WATER: chin., zing.

DIZZINESS (1): Acon., bryo., cocc., opi., phos., puls., sulph., tabac. (2): Ars., camph., canth., hyos., ipec., laur., merc. phos. ac., verat.

FAINTNESS: (1) Ars., camph., cham., chin., hyos., podo., tabac.,

verat.; (2) canth., colch., crot. tig., dios., ferr., ipec., opi., phos., sec., sulph., tart. emet.

MALAISE: (1) Camph., cupr., ipec., nux v.; (2) ars., cham., chin., cic., hyos., merc., sulph., verat.

TINNITUS: (1) Bell., calc., chin., phos. ac., puls., sulph.; (2) acon., cham., cocc., cupr., hyos., nux v., phos., verat.

TREMBLING: (1) Cic., cupr., merc., opi., puls., sulph.; (2) ars., colch., hyos., lach., phos. ac., tart. emet., verat., zinc.

VARIETIES.

a. ASIATICA (epidemic).—(1) In the STAGE OF EVACUATION: ars., sulph., verat.; or crot. tig., ipec., jatr., sec.—*IF DIARRHŒA PREDOMINATES (*coeliorrhœa*): ars., jatr., phos., phos. ac., sec., sulph., verat.—*IF THE EVACUATIONS ARE SERIOUS: ars., jatr., sec., verat.; or ferr., ipec., merc., phos., sulph., tart. emet.; LIKE WHEY: jatr., jod., verat.; WITH WHITISH FLAKES (*rice-water*): ars., cupr., jatr., sec., verat.; or crot. tig., ferr., ipec., iris., phos., phos. ac., merc., tart. e.; WITH EPITHELIAL DÉBRIS: arg. n., brom., canth., colch., coloc., ferr., phos.; COLORLESS: apis, ferr., sec., verat.; ODORLESS: ferr., hyos., paul., rhus, verat.; BLOODY: canth., colch., coloc., ipec., k. bich., merc., merc. c., phos., sulph.; CADAVEROUS: carb. v., chin., kreos., lach., phos., podo., sil., sec., sulph. (*see diarrhœa of premonition*).—*IF VOMITING PREDOMINATES (*cholera emetica*): ars., ipec., jatr., verat., tart. emet.; ALBUMINOUS: jatr., merc. c.; DIFFICULT: tart. emet.; EASY: colch., sec., verat.; HOT: podo.; SEROUS, resembling the stools: ars., colch., cupr., ipec., jatr., sec., verat.; VIOLENT: ars., cupr., tart. emet., verat.; WITH FAINTING: ars., tabac., tart. emet., verat.; WITH INTOLERANCE OF WATER: acon., ars., crot. tig., phos., verat.; WITH NAUSEA: ars., camph., grat., ipec., jatr., tabac., tart. emet., verat.; WITH PAIN IN THE STOMACH: ars., cupr., hyos., ipec., opi., phos., sulph., tart. emet., verat.; WITH RETCHING: hyos., tart. emet., verat. (painful: sec.); PRECEDED BY RETCHING: tart. emet.; MORE RETCHING THAN VOMITING: sec.; WITH TREMBLING OF THE HANDS: tart. emet.; WITH MUSCULAR TWITCHING: ipec., tart. emet., or sulphur; WITH COLD SWEATS: tabac., tart. emet., verat.; EVERY TIME AFTER DRINKING: ars., crot. tig., phos., verat.; ON THE LEAST MOTION: tabac.—*IF CRAMPS PREDOMINATE (*cholera spastica*): (1) cupr.; (2) ars., camph., cic., laur., sec., sulph., verat.—*IN THE ABDOMEN: bell., cocc., coloc., cupr., cupr. ac., ipec., nux, puls., verat.; IN EPIGASTRIUM: dios., nux, puls.; IN HYPOGASTRIUM: bell., cocc., nux; IN THE INTEGUMENTS: ferr.; IN THE

INTESTINES: dios., puls.; IN THE RECTUM: calc.; IN THE UMBILICUS: bell., phos. ac.; IN THE UMBILICAL REGION: bell., mosch., nit. ac., phos., plumb., rhus, stann., tabac.; IN THE UTERUS: caul., cham., cocc., cupr., ign., puls., vib.; IN THE LEFT SIDE: laur., nux; IN THE RIGHT SIDE: laur.; EXTENDING TO BACK: naja.; TO CHEST, towards right scapula: acon.; TO GROINS: k. jod.; TO STOMACH: k. cyan.; IN ALMOST ANY DIRECTION: caul.—*IN THE CHEST: (1) cic., cupr.; (2) angust., camph., ipec., phos., phos. ac., sec., stram., verat.—*IN THE EXTREMITIES: (1) camph., cupr., sec., verat.; (2) ars., jatr., merc., tabac., tart. emet.—*IN THE LOWER LIMBS: (1) cupr.; (2) carb. v., coloc., jatr., phos. ac.; IN THE NATES: verat.; IN THE THIGHS: coloc., phos. ac.; IN THE CALVES: (1) camph., cupr., jatr., sec., verat.; (2) calc., cham., coloc., ferr., ipec., nux v., sulph., tart. emet.; IN THE FEET: camph., sec.; IN THE TOES: sec. or ferr., phos.; IN THE SOLES: carb. v., phos. ac., sec., sulph.—*IN THE ARMS: phos. ac., sec.; IN THE FOREARMS: laur., phos. ac., sec.; IN THE WRIST: phos. ac.; IN THE HANDS: sec., or bell., laur., phos. ac., stram.; IN THE FINGERS: sec., stann., verat., or ars., calc., phos., phos. ac.—*IN THE STOMACH: cupr., or carb. v., phos., sec., verat.

(2) STAGE OF COLLAPSE: Ars., camph., carb. v., cupr., hydr. ac., laur., sec., tabac., tart. emet.—*ALGIDITY (glacial coldness): camph., verat., or carb. v., cupr., hydr. ac., jatr., tabac., tart. emet.; COLD EXTREMITIES: camph., tabac., verat., or acon., ars., ipec., phos. ac., sec.; COLD, CLAMMY SWEAT: camph., tabac., verat., or cupr., jatr., phos., sec., sulph., tart. emet.; COLD BREATH: carb. v., or ars., camph., verat.; COLD TONGUE: carb. v., verat.—*CYANOSIS: carb. v., cupr., hydr. ac., laur., or camph., sec., verat. (see skin).—*SUDDEN SINKING OF STRENGTH: ars., camph., verat., or laur., phos., phos. ac., sec.—*VOICE, FAILING: camph., sec., verat.; HOLLOW: sec.; INAUDIBLE OR LOST: carb. v., cupr., hydr. ac., laur., verat.—*PULSE, FAILING: ars., cupr., dig., ipec., k. brom., merc. c., tabac., tart. emet.; IMPERCEPTIBLE: ars., carb. v., hydr. ac., laur., verat., or camph., cupr., phos., phos. ac., tart. emet.—*FACIES CHOLERICA: ars., camph., carb. v., cupr., hydr. ac., laur., sec., verat.—*SUPPRESSION OF URINE: carb. v., cupr., laur., opi., sec., verat., or ars., camph., hydr. ac., merc. c., stram., sulph.—*PAROXYSMAL DYSPNOEA: carb. v., cupr., hydr. ac., laur.—*INCOMPLETE HÆMATOSIS, *with threatening ASPHYXIA*: amm. carb., carb. v., cupr., hydr. ac., laur., tart. emet.—*IMPENDING PARALYSIS OF THE HEART AND LUNGS: amm., caust., carb. v., cupr., hydr. ac., laur., phos., tart.

emet.—*PARALYSIS OF THE SPHINCTER ANI: phos.; of both SPHINCTER ANI AND VESICÆ: hyos.

OTHER EPIPHENOMENA.—*HEADACHE: bell., bryo., gels., hyos., ign., nux. v., verat.—*VERTIGO: acon., camph., chin., cic., coni., crot. tig., hyos., gels., opi., puls., tabac., verat.—*DEAFNESS: gels., hyos., phos. ac., or arn., chin., phos., sulph., verat.—*ANGUISH (*anxiety*): ars., camph., cupr., phos., sec., verat., or carb. v., lach., laur., phos. ac., sulph.—*MENTAL APATHY: camph., phos. ac., or ars., chin., jatr., lach., merc., phos., sec., verat.—*PROSTRATION, *early*: ars., camph., sec., tart. emet., verat.; *late*: carb. v., hydr. ac., laur., mur. ac.—*SUBSULTUS: hyos., opi.—*TWITCHING OF THE MUSCLES: bell., cic., cupr., hyos., jod., nux v., opi., phos., sec., tart. emet., sulph.—*HICCOUGH: cic., cupr., hydr. ac., hyos., ipec., jatr., phos., verat., zinc.—*STUPOR: bell., camph., hyos., lach., laur., opi., phos., phos. ac., rhus., sec., tart. emet., verat.; *with twitching of muscles*: sulph.—*COMA: bell., camph., hell., hydr. ac., lach., laur., opi., phos. ac., tart. emet., verat., zinc.—*CONVULSIONS: bell., cupr., zinc, or canth., carb. v., cham., cic., hyos., ipec., laur., opi., tabac., verat.—*FACE, DEATHLIKE: ars., camph., carb. v., hydr. ac., laur., verat.; DISTORTED: cic., cupr., hydr. ac., sec., verat.; LIVID: ars., camph., carb. v., cic., cupr., hydr. ac., hyos., ipec., laur., opi., phos., tart. emet., verat.—*LIPS, BLUE: ars., camph., carb. v., cupr., hydr. ac., verat.; COLD: ars., camph., carb. v., cupr., verat.—*TONGUE, LIVID: sec.; COLD: camph., carb. v., cupr., laur., sec., verat.—*THIRST, BURNING: ars., camph., canth., colch., verat.; INSATIABLE: acon., ars., camph., canth., cupr., phos., sec., verat., or colch., ferr., grat., jatr., phos. ac., tabac., tart. emet.; WITH INTOLERANCE OF WATER: acon., ars., phos., verat.; WITH BURNING IN STOMACH AND ABDOMEN: ars., camph., canth., jatr., tabac., verat.; WITH AUDIBLE GURGLING OF DRINKS: cupr., hydr. ac., laur.—*URINE, SCANTY: canth., cupr., hell., hyos., merc. c., opi., or acon., ars., colch., sulph., tart. emet.; SUPPRESSED: ars., camph., carb. v., cupr., hell., hydr. ac., hyos., laur., merc. c., opi., sec., stram., sulph., verat.; INEFFECTUAL DESIRE TO URINATE: cupr., sec., or ars., camph., canth., caust., nux, opi., sulph.; SPASMODIC URGING TO URINATE, *causing spasms*: hell.—*SKIN, LIVID: camph., carb. v., cupr., hydr. ac., laur., sec., verat.; COLD: camph., cupr., hydr. ac., laur., sec., verat., or ars., carb. v., canth., euphorb., hell., merc. c., podoc., tabac., tart. emet.; WITH CLAMMY SWEAT: camph., cupr., jatr., sec., tabac., tart. emet., verat.; DRY: bell., colch., opi., phos., sec., sulph., or acon., ars., bryo., camph., hydr. ac., hyos., merc., rhus.; INELASTIC: ars., cupr., sec.,

verat. ; WRINKLED : cupr., sec., verat., or ars., camph., hell., merc., phos. ac., sulph. ; FOLDS PERSISTING WHEN PINCHED UP : sec., verat.—*HEART, IRREGULAR ACTION : ars., camph., laur., opi., phos. ac., sec., sulph., or acon., carb. v., cic., rhus., verat. ; FEEBLE : hydr. ac. ; CONSTRICTED : ang., cact. ; OPPRESSED : tabac.—*PRÆCORDIAL DISTRESS : acon., ars., camph., cupr., ipec., tabac., tart. emet., verat.—*RESPIRATION, FEEBLE : camph., cupr., hydr. ac., ipec., laur., opi., sec., verat. ; LABORED AND ANXIOUS : ars., carb. v., cic., cupr., ipec., hydr. ac., laur., opi., phos., sec. ; OPPRESSED : ars., cic., cupr., hyos., ipec., lact., laur., phos., sec., sulph., verat. ; SNORING : laur., opi. ; WITH PAROXYSMS OF SUFFOCATION : ars., camph., carb. v., cupr., ipec., hydr. ac., lact., laur., opi., phos., samb., tart. emet., verat..

(3) STAGE OF REACTION.—INCOMPLETE.—*FOLLOWED BY CONGESTION OF THE HEAD : acon., bell., merc., opi.—*BY CONGESTION OF THE LUNGS : acon., bryo., phos., or ferr. phos.—*BY ENTERITIS : acon., bell., canth., coloc., merc.—BY NEPHRITIS : acon., bell., canth., cocc. c., lyc., nux, phos., puls., sene., tereb.—*BY THE TYPHOID STATE : hyos., phos. ac., or bapt., bryo., gels., mur. ac., opi., phos., rhus.—*BY URÆMIA : agar., amm. c., ars., bell., cupr., hydr. ac., laur., opi. ; WITH CEREBRAL HYPERMÆMIA : apis, bell., coni., cupr., gels., glono., opi., stram. ; WITH SOPOR : opi. ; or agar., bell., cic., hell., hydr. ac., lact., laur. ; WITH CONVULSIONS : agar., cic., cupr., hydr. ac., laur., opi. ; WITH ANÆMIA AND PARALYTIC SYMPTOMS : ars., camph., china, chin. ars., phos., phos. ac. ; IF IT SETS IN WITH SEVERE HEADACHE : cann. ind., bell.—*RETURN OF ALGIDITY : verat. ; OF CRAMPS : cupr.—*DELAYED SECRETION OF BILE, *the stools remaining colorless* : sec.—*DELAYED SECRETION OF URINE : cupr., hyos ; FROM ATONY : opi.

(4) SEQUELÆ.—*ABCESSES : bell., hep., merc., sil. ; *erysipelatous* : apis, bell. ; LIVID : lach.—*BOILS, *multiple* : arn., ars., nux v., sulph. ; *from exhaustion* : chin., lach.—*BEDSORES : arn., ars., chin., lach., plumb., sulph.—*ULCERATION OF THE CORNEA : ars., calc., euph., hep., k. bich., lach., merc., nat. m., sil., sulph. ; SLOUGHING : calc., hyp., hep., sil.—*CONSTIPATION OBSTINATE : alum, lyc., nat. m., nux v., opi., plumb., sulph. ; AFTER PROLONGED PURGING : alum, lach., nux v., opi.—*DIARRHŒA, OBSTINATE : ars., hep., phos., phos. ac., podo., sulph. ; WITH ABSENCE OF BILE, *colorless* : sec. ; EXHAUSTING, WATERY STOOLS, *with emaciation* : œnoth. ; WHEY-LIKE : jod. ; WITH MUCH THIRST, RUMBLING AND DEBILITY : phos.—*DEBILITY, *general* : ars., chin., nux v., phos. ac.—

*DYSENTERY: acon., colch., coloc., ipec., nux v., merc., sulph.—
 *DYSPEPSIA: ant. c., ars., bryo., carb. v., ipec., lyc., nux v., puls., sulph.—*ERUPTIONS, VESICULAR (rare): ars., rhus, sulph., or clem., dulc., graph., lyc., merc., olean., sep; ERYTHEMA: acon., apis, ars., bell., merc., mez., rhus; ROSEOLA: acon., bell., bryo., puls.; URTICARIA: ant. c., apis, ars., calc., caust., cop., dulc., mez., nit. ac., rhus, urt. ur., sulph.—*GANGRENE OF THE NOSE: sec., *phagedænic*: aur., merc.; OF THE BUCCAL CAVITY: ars., lach.; OF THE LOWER LIMBS: ars., carb. v., chin., lach., sec.; OF THE GENITALS: ars., canth., plumb., sec.; OF THE PENIS: canth., laur., plumb.; OF THE SCROTUM: ars., plumb.; OF THE UTERUS: sec.—*HICCOUGH: cyc., hyos., ign., nux v.; AFTER EATING, *making pit of stomach sore and aching*: phos.—*INTELLECT, IMPAIRED: acon., anac., ars., aur., bell., cann. i., hyos., lach., lyc., nux v., opi., phos. ac., plat., puls., sep., stram., sulph.—*PARALYTIC TROUBLES: acon., agar., alum, angust., ars., bell., bryo., calc., carb. v., caust., cic., cocc., gels., hyos., k. phos., lach., lyc., nat. m., nux v., opi., phos., pic. ac., plat., plumb., rhus, sec., sil., sulph., verat., zinc.; FROM DEBILITATING LOSSES: chin., ferr., verat; AFTER THE TYPHOID STATE: cocc., cupr., rhus, sulph.; OF THE INTESTINAL CANAL: camph., opi.; OF THE RECTUM AND SPHINCTER ANI: aloë, apis, hyos., opi., phos., sulph., zinc.—*PAROTITIS: bell., merc., rhus; WHEN SUPPURATING: ars., ars. jod., phos., sil.; WITH FISTULOUS OPENINGS: lyc., nit. ac., phos., phyt.—*PAINFUL TETANIC CONTRACTIONS *of the flexor muscles of the limbs*: ang., cic., cimex., crotal., cupr., ign., hydr. ac., laur., opi., sec., tabac.—*PROFUSE SWEATS: bryo., chin., merc., phos., phos. ac., samb.; IN THE MORNING: chin., phos. ac., sulph. ac., sulph.; AFTER WAKING: merc., puls., sulph.; AT NIGHT, DEBILITATING: chin., merc., phos., sil., stam.—*CONTINUED SUPPRESSION OF URINE: ars., canth., k. bich., tereb., sec.; SCANTY FLOW: canth., cupr., hyos., opi., stram.

b. CHOLERINE: Ars., ferr., grat., ipec., jatr., phos., phos. ac., pod., sulph., verat.—*WHILE THE STOOLS STILL REMAIN FECAL: ars., ipec., phos., verat.—OBSTINATE DIARRHŒA: ars., phos. (see diarrhœa of premonition).

c. CHOLERA ASPHYCTICA: Amm. c., camph., carb. v., cupr., hydr. ac., laur., opi., tart. emet., verat.

d. CHOLERA INFANTUM: (1) Æth., ars., bell., bis., crot. tig., ipec., k. brom., laur., mag. c., sulph., verat. (2) acon., ant. c., apis, borax, calc., camph., carb. v., cham., chin., cina, colch., elat., gamb.,

grat., iris, jatr., phos., phos. ac., podo., puls., raph., sec., sil., tabac., thuj.

e. CHOLERA MORBUS: (1) Ars., crot. tig., elat., ferr., grat., ipec., jatr., podo., sec., verat. (2) Ant. c., camph., cham., chin., colch., coloc., euphor., gamb., iris, mag. c., phos., phos. ac., tabac., tart. emet.

f. CHOLERA SICCA: Camph.; WITH SYMPTOMS OF IMPENDING ASPHYXIA: laur.

In the above repertory I have endeavored to include all those cholera symptoms and syndromes, observed and reported by foreign physicians, with and without Indian experience. I have also searched with the greatest care the corresponding remedies, hoping that my work may prove in the future useful to those who believe in the individualization of cases and efficacy of the *similimum*.

THE MANAGEMENT OF PLACENTA PRÆVIA.

BY W. J. MARTIN, M.D., PITTSBURGH, PA.

(Read before the Allegheny County Homœopathic Medical Society, March 10, 1893.)

I HAVE chosen this subject for consideration this evening for the reason that it is eminently practical and of interest and importance to every physician; and although it is estimated that placenta prævia occurs but once in every five hundred pregnancies, there is not one of us here this evening but may be called upon to take charge of a case of this kind before to-morrow morning. Therefore, it is highly important that we should be clear in our minds as to what is best to do, and how best to do it.

I will give you my views upon this matter based upon a study of the literature on the subject at my command, and some personal experience, hoping that my remarks will call forth the views of others if differing from mine, as well as their experience in the management of this difficulty.

Time would be wasted in theorizing as to the probable cause or causes of placenta prævia. It is enough to say that we do not know the cause, and it is doubtful if such knowledge would be of any practical use to us if we had it.

The recognition of the existence of the trouble is not difficult. A

painless and apparently causeless hæmorrhage during the latter months of pregnancy, or a free bleeding during the first stage of labor should always arouse our suspicion, and if in the latter months of pregnancy, and labor has not set in, every recurrence of this hæmorrhage should confirm our suspicion. If labor has set in, then our suspicion should be verified at once by digital examination, when if the case is one of placenta prævia, the examining finger instead of coming in contact with the smooth surface of the foetal membranes, feels the thick fleshy structure of the placenta, and as you feel all of the surface within the reach of the finger, it gives you the idea of an uneven, spongy, granular mass. If your case is one in which labor has not set in and the cervix is high up and but slightly or not at all dilated, it will be difficult and perhaps impossible to reach the placental surface. If after using every effort to get the finger within the os internum (even going so far as to introduce the hand into the vagina), you fail, then the recurrence of hæmorrhage without known cause or pain, will be sufficient to justify the diagnosis of placenta prævia.

The prognosis is bad both for mother and child. The mother is in peril from loss of blood. The child from asphyxia, his means for oxidation being withdrawn *pari passu* with the detachment of the placenta. The prognosis therefore for the child is very bad.

Having in a given case, arrived at a diagnosis, and bearing in mind the very unfavorable character of the prognosis, the patient and her family should be enlightened as to the exact condition of affairs, and counsel and assistance secured. The consultant should be a man in whose ability and good judgment you have full confidence.

In considering the treatment a distinction must be made as to whether or not the patient is at term when you are first called to her. If she is at term, uterine contractions have probably already begun, or if no signs of labor are yet present, they will soon appear.

We will first speak of the management of a case of this character, after which we will consider the management of a case where hæmorrhages are occurring one or two months or more before term and no signs of labor setting in.

When the trouble reveals itself first at the onset of labor, we must hasten as much as possible the dilatation of the cervix. If pains are absent and the cervix closed and the bleeding very free, it is best to tampon the vagina and elevate the foot of the bed and lower the patient's head and shoulders; at the same time administer

the remedy called for by the symptoms. You should remain with the patient and as soon as the character of the pains makes it likely that dilatation of the cervix has begun, the tampon is to be removed and dilatation hastened either by the manual method or by Barnes's bags. Whichever method is employed, it is best to have the patient under chloroform, and give a preliminary vaginal douche of carbolic acid 1 to 100. Dilatation by the hand is accomplished by introducing the hand into the vagina, having first scrubbed the hand and thoroughly cleaned the nails, then pass one finger, preferably the middle one through the internal os into the uterus; follow this as rapidly as possible with the index finger and with these two fingers stretch and dilate the os until another finger can be gotten in, continuing on in this way until the hand is passed in. This is painful and tiresome to the operator, but equal, if not superior to any other method.

If Barnes's bags are preferred to the manual method, the smallest sized bag is taken, washed in carbolic acid solution, well greased and pushed through the os on a staff, then the bag is connected with a Davidson syringe and gradually dilated to its full extent with a weak, warm carbolic acid solution. (The warm carbolic solution is used because the bag may burst.) When this has been accomplished this bag is removed and a larger size introduced and dilated. The third and largest bag produces sufficient dilatation to allow of the introduction of forceps or a hand. With this amount of dilatation secured we are already to take the next step.

The woman, still under chloroform, is placed in the forceps position, the hand introduced into the vagina and two fingers passed into the uterus and a search made for an edge of the placenta, which, if the implantation is not central, is soon found. If the implantation is central more fingers and if need be the hand entire is passed between the placenta and uterine wall until an edge of the placenta is reached. Make out, if possible, the position of the child, noting whether the occiput is to the mother's right or left; then pass a female catheter along the fingers of the hand in the uterus, puncture the membranes and draw off the water. Now withdraw the hand and rapidly prepare for turning the child. The hand that corresponds to the position of the child's occiput—that is, the right hand if the occiput is to the mother's right, and the left hand if it is to the mother's left—is bared to above the elbow, scrubbed, bathed in a 1–2000 bichloride of mercury solution, well greased except the palmar surface of the hand, and passed into the womb; feel for the cord to determine if it

is pulsating or not, then secure both feet if possible, or if this cannot be accomplished take one and draw it out, at the same time pushing up the child's body and head with the outside hand. With the feet, or one foot out, bleeding will almost cease by reason of the strong pressure on the placental vessels made by the child's legs and breech. Active operations should be suspended now for a time in the interest of the mother, whose death might result from the too sudden emptying of the womb. The bleeding is now under control and if it should recommence we can draw down upon the legs sufficiently to check it.

If the cord was found to be pulseless we know the child is dead, and can proceed with the delivery slowly, but if it was not pulseless we should endeavor to save the child as well as the mother, and deliver as rapidly as the dilatation of the os will permit. After the delivery of the child the placenta is removed at once, contraction of the womb encouraged by the Credé method and the case conducted thenceforward as after any difficult labor.

Two other plans have been proposed. One is to insert the fingers into the os and peel off the placenta entirely from its attachments to the womb, when, it is claimed, the hæmorrhage will cease and the labor may be allowed its own time for completion. How true this is I cannot say, but I feel very certain the child would be lost every time. The other plan proposed is to dilate the os sufficiently to pass the forceps, and then with the hand wade right through the placenta, apply the forceps to the child's head and deliver. This it appears to me would be a very bloody operation, and consequently very dangerous to the mother, unless done with remarkable speed. My own judgment and the little experience I have had lead me to conclude that the procedure I have described (version) is the best we have. My experience has been that the mother has been saved every time, and in my latest case the child too.

We now come to the consideration of a part of this subject upon which sometimes it is very difficult to make up one's mind.

We will suppose that we are called to a woman about seven months pregnant, taken with a sudden painless and causeless hæmorrhage. We, of course, exert our best efforts to the checking of the hæmorrhage. The bleeding having stopped, what is to be the subsequent management of the case? This is the question that has worried me almost sick. One authority—and a recent one—says, "In cases of central implantation the patient is liable to be seized suddenly and without apparent cause, perhaps during sleep, at any

time during the last three months of pregnancy, with a severe hæmorrhage. It may leave her blanched and pulseless, or it may cease spontaneously. But the important thing to remember is that such a hæmorrhage having once occurred, there is no safety to that patient until the child is born. The bleeding is liable to return at any moment with the most alarming and even fatal consequences. Inasmuch as the peril is from the hæmorrhage coming at an hour or in a place where skilled attention cannot be at once had, the safest course is the following: As soon as the diagnosis is established, and confirmed by one or more hæmorrhages, the pregnancy is to be ended immediately by the separation of the membranes and the early introduction of a cervical plug which shall at once dilate the cervix and restrain bleeding." Dilatation to be completed with Barnes's bags and the child delivered by turning. "The physician should not leave the patient until the labor is completed."

I have found that it is not always possible to obtain the consent of the patient and family to the induction of premature labor, and I cannot bring myself to believe that it is always the best thing to do. If the patient is strong and bearing up well under the repeated bleedings, we can watch the case closely, giving the remedy called for by her symptoms, and carry her through until labor sets in spontaneously, and then proceed to hasten delivery, in which case if the patient dies there will be less ground for criticism than if we had produced premature labor by manual interference. It is a fact, too, worthy of remembrance in this connection that in about one-half of these cases the pregnancy is prematurely terminated by nature. This favors conservative and expectant measures. If we could be sure that after the induction of premature labor and delivery, the woman would in every case recover, then it would be the only proper course to pursue in all these cases. But we can make no such promise, for the patient may die while undergoing the operation or soon after it, and indeed there might be persons who would say, in consequence of it.

But on the other hand, if while watching the case closely and doing our utmost to conserve the patient's strength, we find that she is becoming seriously endangered from repeated heavy losses of blood, then it is our duty to hesitate no longer as to the propriety of inducing premature labor. And if the patient or her family refuse their consent, then the physician's duty to himself is to refuse to have anything more to do with the case.

PROFESSOR JAMES'S CLINIC, TOGETHER WITH A REPORT OF SIX
MONTHS' WORK IN THE SURGICAL WARDS OF THE
HAHNEMANN HOSPITAL, OF PHILADELPHIA.

BY CARL V. VISCHER, M.D.

(Read before the Homœopathic Medical Society of the County of Philadelphia, March 9, 1893.)

UNTIL within the past few years it has been the wonted cry of "our friends, the enemy," that we as homœopaths disregarded all branches of medicine save those pertaining directly to *materia medica*, and hence failed to consummate much good that might accrue from the application of principles other than therapeutic. We were unknown as surgeons, pathologists, bacteriologists, etc., and therefore were recognized only as medical men in the stricter sense of the term, dogmatic, hide-bound and non-progressive. I feel that my argument of this evening will convince the most skeptical that our proclivities in directions other than those of medicine were much alive, and only thwarted by the positive selfishness manifested in the refusal of granting positions, offering opportunities for the development of the various specialties. Now that facilities and material in abundance are at our command, we no longer can be viewed in the same light as a few years since. Having specialists of experience and ability in all the various branches of the medical sciences, we stand to-day the peers of all. To-day the Surgical Clinic of the Hahnemann College Hospital is recognized as one of the leading clinics in the city of Philadelphia, being attended by students of all the other schools in the city as well as those of our own. This is due not as much to the numerous and various operations performed before the class, as it is to the efforts of Professor James, who conducts the clinic in a systematic manner according to the latest recognized surgical principles, which it shall be my endeavor to portray in the following pages.

The clinic is held weekly, on Saturday, at two o'clock, in the amphitheatre of the hospital, which has been constructed in accordance with the latest sanitary measures. The few necessary apparatus are made in consistence with the aseptic principles of surgery, which principles are carried out as far as practicable and possible in the treatment of all cases. Adjoining the operating theatre on either side is an ante-room, which is used for anæsthetizing and for the proper disinfection of dressings, together with appurtenances for the preparation of the operator and assistants. During the past winter sterilization by boiling and condensed steam, where possible, has been employed as a disinfectant in preference to the use of drugs;

only in exceptional cases bichloride of mercury and other antiseptics were employed. For irrigating and sponging sterilized water was used. Instruments were all thoroughly boiled prior and after each operation; during use they were immersed in a sterilized water containing 3 per cent. of a bicarbonate of soda. The various sewing material was kept aseptic either by boiling previous to being used (as silk) or in bichloride of mercury and alcohol, after careful cleansing (as catgut and silkworm-gut). Tampons were preserved in bichloride solution after being sterilized with compressed steam. Drainage tubes were kept in a carbolic-glycerine solution. The dressings used were iodoform gauze and occasionally powder composed of one part of iodoform and nine parts of boracic acid. Further than this, peroxide of hydrogen, and occasionally Thiersch's solution, were employed as cleansing agents. The patients were prepared for operation in the customary manner, the field of operation being cleansed several hours previous to being attacked by repeated scrubbing with *sapo viridis* and water, after which the parts were shaved, rinsed and covered with an antiseptic compress. This process was repeated just prior to operative interference, the final rinsing fluid here being alcohol. The hands of the operator and assistants were simply thoroughly cleansed by repeated scrubbing and finally bathed in alcohol. Operating gowns, towels, as well as all linen coming in contact with the field of operation, were thoroughly sterilized previous to being used.

This method has now been employed with slight modification for two consecutive sessions; and it is believed, judging from the results obtained to be at least, equal though somewhat more difficult to practice than the antiseptic method over which it possesses obvious advantages. It cannot be said that there was an absolute freedom from suppuration, though frequent attempts were made to obtain primary union in both deep and superficial wounds; the success, however, was only partial, as in many instances the wound in part gaped owing to a too rapid absorption of the stitches, or in others the stitches had to be removed to give vent to some pus, therefore we must prove an exception to the frequent reports of series of cases that have healed "without a drop of pus formation." True, it is however, that aside from having many wounds heal by secondary union, there was an absolute freedom from any complications; and the pus we had to contend with was formerly known as "laudable." Efforts were constantly made to discover the source or reason of interruption to primary union, and though it was once thought to be due to some sewing material it was learned differently. We have

no hesitancy in the least, to acknowledge that pus formation followed some operations; inasmuch, as after long and careful practice and observation with the antiseptic methods of treating wounds, we have found suppuration to be equally common; and from these observations I am led to believe there is another and important factor connected with the healing of wounds, that although known, is seldom considered or recognized in speaking of either, the success or opposite in surgical practice; I have reference to "individual predisposition." It is a well-known fact that those suffering from some constitutional dyscrasia, such as syphilis, tuberculosis, etc. Wounds as a rule heal less kindly, though there are some marked exceptions that prove the rule. Still another factor not to be forgotten is "local predisposition," if you please, many regions healing kindlier than others, as for instance, wounds about the face; this may be due, to the vascularity, and I am inclined to believe it is, for obvious reasons. To the best of my knowledge, with the exception of some incomplete observations made in this direction by Mikulicz, the subject of predisposition of individuals and various tissues, has received but little or no attention. The author is at present interested in investigating the subject and hopes at some future time to present the results of the same. For the privilege of presenting the following tabulated report, together with a sketch of a few of the more interesting cases, I am indebted to my senior, Dr. James.

From the 1st of September, 1892, to the 1st of March of the current year, there were 1002 cases admitted to the accident ward; of these there were:

Burns,	52
Contusions,	229
Contused wounds,	54
Concussion of the brain,	4
Epistaxis,	3
Fractures (15 of which were compound),	125
Frost bite,	12
Foreign bodies in various parts,	71
Gunshot wounds,	5
Incised wounds,	104
Luxations,	14
Lacerated wounds,	409
Poisoned wounds,	8
Punctured wounds,	49
Retention of urine,	5
Sprains,	56
Strangulated hernia,	2

Showing an increase of about 200 cases over the same period of

last year. There were 200 cases admitted into the wards. The following is a list of the operations, most of which were performed before the class :

Abscesses opened in various parts,	38
Amputation of the breast,	11
Amputation of the arm,	1
Amputation of the foot,	1
Amputation of the leg,	3
Amputation of the thigh,	4
Amputation of the toes,	5
Appendicitis,	1
Arthrotomy,	2
Castration,	5
Colotomy,	1
Cholecystotomy,	2
Circumcision,	4
Empyema,	3
Enucleation of tumors,	13
Epicystotomy (2 for stone and 1 for tumor),	3
Exploratory incisions of scalp,	5
Fistula, anal,	5
Hæmorrhoids, radical operation,	8
Hare lip,	2
Herniotomy,	8
Hydrocele, radical operation,	7
Imperforate anus,	1
Internal urethrotomy,	4
Laparotomy,	3
Necrotomy,	8
Osteotomy,	2
Paracentesis of abdomen,	1
Paracentesis of thorax,	1
Paracentesis of tunica vaginalis,	1
Perineal section,	14
Resection of superior maxilla,	1
Skin grafting (Thiersch's method,	2
Trephining (1 of which was therapeutic),	10
Tenotomy,	4
Thyroidectomy,	1
Varicocele,	3
Wiring of ununited fracture,	1

Making a total of almost 200 cases operated upon, which is an increase of about 85 per cent. over the corresponding period of last year. Of the 12 deaths which occurred but two are directly traceable to operative interference, one a case of impermeable urethral stricture where perineal section was done, died some three weeks later from so-called urethral fever. The other a case of empyema

in a child four years of age, where free drainage was established, but which succumbed shortly following the operation. The other deaths were mostly accident cases which were brought to the hospital in a moribund condition.

At the present day one almost feels like offering an apology for presenting anything short of a series of cases, as operations that were considered interesting and unusual a few years since have grown to be of nearly daily occurrence, and consequently have become familiar to us all. It has however been my good fortune the past three months to meet with three consecutive cases of choliolithiasis, two in hospital practice and one in private, the nature of which though a common complaint, has been somewhat out of the ordinary, and therefore of considerable interest, especially as the surgical treatment has been more fully developed within the past few years, and furthermore the intervention of surgical interference being as yet comparatively infrequent. So that I believe their consideration will prove not uninteresting, though they did terminate fatally.

CASE I.—Mrs. N., æt. 72, was admitted into the hospital September 9, 1892, suffering from a swelling in the right hypochondriac region which was first noticed about a month previous to her admission; this gave rise to considerable pain, lancinating in character. The growth was found to be freely movable and quite sensitive to touch, the liver was some little enlarged. Her temperature on admission was normal, but shortly after she was taken with a violent chill followed by a rise of temperature to 102° .

It was quite evident the tumor consisted of a distended gall-bladder, and together with the chill it was believed pus had formed. An abdominal section was made and the gall-bladder found as described, on incising it two large calculi together with a quantity of thin pus was removed. The bladder wall was tacked to the parietal peritonæum with several fine silk sutures and the abdominal wound closed, after introducing a drain into the gall-bladder the wound was dressed with iodoform gauze cotton and a binder. Her progress was very good until the eleventh day, when she suddenly collapsed and died.

CASE II.—Mrs. C., æt 67, was admitted to the hospital on November 10, 1892, also suffering with a tumor in the right hypochondrium, which had existed for some two years, but not until the last six months did it give rise to any inconvenience, since which, however, she has been complaining of considerable pain which comes in paroxysms, lasting but a few moments at a time. With these pains which radiated from the site of the growth throughout the abdomen, she noticed a gradual failing in health which became especially conspicuous during the past few weeks, and which induced her to seek

relief. Examination showed the patient to be extremely emaciated and somewhat cachetic in appearance. The abdominal walls being thin the tumor, which was fully the size of a fist, was found situated considerably below the liver, and was freely movable. At times, the growth appeared larger than at others. Palpation showed it to be very sensitive. The temperature ranged between 99° and 100° . Pulse fair but rapid. A diagnosis of empyema of the gall-bladder together with stone and the probable existence of a malignant growth was made. Operation was offered as her only chance, and in spite of an unfavorable prognosis she urgently requested it to be done. Accordingly on November 12, 1892, in presence of the class, Dr. James opened the abdomen in a line over the tumor, and at once came down on a greatly distended gall-bladder, which, after withdrawing several ounces of a very liquid pus, was incised, and some fifty-six calculi removed, seven of which, were about a half inch square, the remainder varying in size from a small pea to that of a large bean. The posterior wall of the bladder, the common duct together with a large portion of the liver was found infiltrated; a mass the size of an egg was seen binding the bladder and adjacent organs together; this was unquestionably carcinomatous in its nature. The extent of liver involvement excluded all hopes of removing the diseased mass, so that the walls of the bladder were sutured to the parietal peritonæum, and after introducing a drain the wound was dressed in the customary way. The patient reacted slowly, only to sink into an asthenic condition, in which she died on the third day following the operation.

CASE III.—Mrs. V., æt. 64. Had been ailing for a number of years, her trouble, however, always being attributed to indigestion, aside from which she enjoyed usual good health, was taken rather suddenly with a severe pain in the epigastrium, which gradually centred in the cœcal region; the temperature ran up to 102° , the pulse was considerably increased; with this there was continuous nausea, some little vomiting, and marked constipation. An examination proved rather difficult, owing to the thick and pendulous abdominal walls. With some care, however, a tumor indistinct in outline could be detected in the right side of the abdomen, but somewhat higher than those due to appendicial troubles are usually found.

Upon careful observation it was seen that the swelling was rapidly increasing in size, and under considerable pressure indistinct fluctuation could be detected. Her general condition having grown considerably worse, an exploratory operation was advised and done. After being under the influence of ether the tumor could be more readily defined, when it was found that it extended up toward the liver. This led to the opinion that the trouble was in the gall-bladder, in preference to the appendix, which was first suspected as the seat of the difficulty. On opening the abdomen in the right semi-lunar line, the fingers were introduced in the direction of the appendix, which was found normal both as to appearance and posi-

tion. Passing the fingers upward, the growth was met and discovered to be the gall-bladder, which was fully as large as a good-sized apple. The duct and neighboring tissues seemed unaltered, save a few adhesions of the omentum to the apex of the bladder. After drawing the bladder into the wound, the abdominal incision was in part closed, following which the gall-bladder was opened, the walls of which were found to be much hypertrophied; a large calculus was removed together with some three ounces of pus. The duct was very much dilated, easily permitting the introduction of the end of the index finger. A fistula was made, but in place of stitching the bladder-walls to the parietal peritoneum, as in the preceding cases, it was tacked to the integument, owing to the thickness of the abdominal parietes. The patient did well until the end of the fifth day, when she became excessively nervous, finally developing into almost a maniacal condition, from which she succumbed.

A point worthy of remembrance in connection with these cases is the absolute freedom from jaundice and all subjective symptoms leading to biliary trouble. In cases I. and III., it can be easily understood why there was no obstruction, the calculi being too large to enter the duct, and consequently could not give rise to any permanent obstruction. In case II., however, there also being numerous small stones, the absence of icteric symptoms is not so readily accounted for.

CASE IV.—Mr. K., æt. 54, was received into the hospital suffering from symptoms pointing to vesical calculus. An examination of the bladder revealed a tumor in the right lower portion of that organ, which appeared quite firm. Rectal examination showed it to be somewhat above the prostate, which gland was also slightly enlarged. On opening the bladder by the supra-pubic route, it was seen that the growth was cystic and sessile, apparently having its origin in the sub-mucous tissue. The contents proved to be a thin, watery fluid, unlike that usually found in mucous polypi. The walls of the cyst seemed like greatly-hypertrophied bladder mucous membrane. The case is of interest from its great rarity, and is more fully described in a paper by Dr. James.

CASE V.—Mrs. F., æt. 24. Has enjoyed general good health until some five weeks since, at which time severe abdominal pains were ushered in by a chill, with a rapid rise of temperature to 104° ; nausea and some vomiting, with a slight diarrhoea, which soon gave way to obstinate constipation; abdomen distended and painful. This was at first suspected as a case of appendicitis until it was observed that a tumor was developing in the left side of the abdomen. She now began to rapidly grow worse, her countenance becoming markedly abdominal, the pulse small and rapid, the temperature ranging from 99° to 103° . An examination at this time showed a distinct unilateral enlargement, which was ill-defined. Palpation elicited fluctuation, which, however, was not confined to the swelling, but extended throughout the abdomen. Percussion was, of course, dull. An immediate exploratory incision was advised, which was done at

once after her admission into the hospital. The abdomen having been opened in the median line, some three or more quarts of flocculent pus escaped. The pus cavity was between the layers of the peritonæum, which membrane was covered with granulation tissue characteristic of tuberculosis. On the left side of the abdomen, near the umbilicus, a firm adhesion was found, which gave the swelling its symmetrical appearance.

Having gently curetted the abscess cavity, it was thoroughly irrigated with sterilized water and packed with iodoform gauze. Her temperature immediately after the operation fell to near normal, where it remained, the patient making a rapid and uneventful recovery.

CASE VI.—Mr. O., æt. 21. Had been suffering some ten days from an attack of appendicitis, which was rather irregular in its course. On the eleventh day a large quantity of pus was discharged per rectum, after which the patient rallied from his collapsed condition only to show signs of the same soon after. When I first saw the patient the Hippocratic countenance was well marked and the pulse typically peritoneal in character. Temperature 99° ; abdomen distended and slightly sensitive to the touch; percussion revealed dulness over the right half. On having him transferred to the hospital, the abdomen was immediately opened in the right semi-lunar line, which gave vent to a quantity of fæcal pus. On introducing a finger, a large cavity was found completely shut off from the general peritoneal cavity, which ran up toward the liver. After enlarging the incision in that direction, the appendix was found firmly adherent to the colon near its hepatic flexure, into which it had perforated. Furthermore, it was found that it was gangrenous. The condition of the patient did not warrant further operative interference, had it been deemed justifiable. So that, after making a free incision through the loin for drainage, the parts were thoroughly irrigated and dressed in the usual manner. He rallied slowly, only to succumb on the fifth day following the operation from a general septic peritonitis. This case is interesting from its irregular course, and in that the appendix was found in an extreme abnormal position.

Together with these we have had a series of cases that might possibly be of interest, which, however, we prefer accumulating until such a time as we may feel justified in forming definite conclusions.

KALMIA LATIFOLIA IN HEADACHE.—Dr. Pröll records the case of a thirteen-year old son of a banker who suffered from headache and weak memory to such an extent that he was obliged to leave school. The cause was found to be due to an insufficiency of the cardiac valves, and *kalmia* 1c. was given three times a day. In three days there was a slight improvement, when the remedy was administered twice a day, in the second centesimal dilution. The headache then appeared only occasionally. The third centesimal was substituted for seven days, when the headache wholly disappeared in spite of the persistence of the heart lesion. At present, seven months after, the child continued his studies without interruption.—*Homöopathische Monatsblätter*, No. 1, 1893.

A CASE OF ORIFICAL SURGERY.

BY W. G. STEELE, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

THE following is a case of orificial surgery, where the relations between cause and effect are so pronounced, as to prove conclusively that orificial philosophy is not merely a new fad, but that it is built upon a scientific foundation that will stand under the test of experience.

Mrs. X., æt. 30 years, was delivered of a child in January, 1892. Of the labor I cannot speak as it was attended by another physician. On February 24th following the delivery, she was impressed with the idea that something was about to happen to her, and that her natural feeling was taken from her. She felt as though her mind was leaving her, and a strange feeling came over her, which she described as a "chilly crawling proceeding from the left foot to the head." This would leave her for awhile and return at intervals. This was followed by various hallucinations.

Her physician, an old-school doctor after exhausting his resources, said she did not need any more medicine and ceased to prescribe for her, notwithstanding that the patient was constantly growing worse. I saw her first on March 29th, 1892, when her symptoms were as follows: her physical condition seemed fairly good, quite up to the average. Her husband, and her two children seemed strange to her; in fact everything seemed strange to her, notwithstanding that she realized that they were all right to other persons. With the above symptoms there was what she described as an internal cursing of everything that she looked at, including animate, and inanimate objects; this cursing was of course inaudible, only having existence in the mind of the sufferer; even her children were objects of these unnatural phenomena; although, so far as I can ascertain, she never harmed any one, she constantly lamented her condition and expressed herself as being under the control of two distinct will-powers; she in fact, presented the characteristics of that curious phenomenon formerly described as "possession." She would cry and moan aloud, and walk the floor, wringing her hands and pulling her hair, and at times would drop to the floor regardless of her surroundings, and give vent to wailings, disturbing her neighbors. During these attacks she would

frequently strike her head and beat it against the wall in attempt to kill herself. The only relief experienced was when asleep, during which time she was unconscious of her misery. She would frequently pray to die. She was of a religious turn and strove to overcome the evil influence that seemed to control and overwhelm her. She had a singular expression of countenance, her eyes had a weird, horrid expression, forehead wrinkled, brows contracted, in fact the gaze of confirmed insanity. Prior to her affliction she was neat and tidy; now, she was in all respects quite the reverse, her clothing was disordered, hair unkempt and her whole appearance betokened insanity. Periods of time were unnatural to her. An hour seemed like a day, and a day like a week. Notwithstanding these mental aberrations she attended faithfully to the wants of her two children, but did it by a sort of mental projection out of her own disordered intellect. Her appetite was insatiable, to the extent of eating garbage from the garbage boxes along the street, notwithstanding she had a good home. After a short and unsuccessful medical treatment by me, she was induced to consult an electrical specialist in high standing in the old school, but his efforts were not successful. Next, Christian science was called to her aid but without avail.

During the summer of 1892, I attended a course of lectures by Professor Pratt, at Chicago, and while there conceived the idea that this woman would be a good subject for orificial surgery. On my return I made my views known to the patient and her husband, and in sheer desperation, with but little hope of success she placed herself again under my care.

On resuming the case I learned that she had been addicted to the habit of masturbation since her fourteenth year, which she performed in a very peculiar and novel manner, the method of which was to me new. I was led to believe that the hypertrophy of the labia minora, which was considerable and the constriction of the hood of the clitoris, which I discovered on examination, might have been a prime factor, not only, in the development of the masturbating habit, but also of the insanity which was possibly dependent thereupon. When seated on a chair, she would throw the left leg over the right, and grasping the back of the chair turning her body half way round to the right to accomplish this, she would alternately raise and lower herself until the orgasm was induced by the friction of the labia against the adjacent parts. She assured me that she never experienced the orgasm in connection with her husband, but would sometimes resort to the above method; or more frequently, by cross-

ing the thighs while in bed would raise and lower herself while in the horizontal position, until the orgasm was produced. The above statement was corroborated by the husband of the patient. She assured me that she has not practiced the former manipulation often since marriage. It was the above deduction which led me to perform my first operation on those parts, and to defer my second operation on the cervix uteri until I had positively determined, whether or not this connection existed in reality.

On November 11, 1892, under the influence of ether, administered in large quantity by a skilled anæsthetist, I observed that the labia minora still continued to retain their sensitiveness, so that it was with difficulty that I succeeded in amputating them and the hood of the clitoris, the patient frequently giving evidence of sensibility by twisting and turning on the table; this further confirmed my belief in the connection between these abnormalities of structure and the concomitant aberrations of intellect, and that permanent benefit would result from their removal. Examining the cervix uteri at the same time, I found it in a state of subinvolution, with *incomplete* bilateral lacerations and evidence of endocervicitis. As the patient had already consumed a large amount of ether and the operation for repair of lacerated cervix is somewhat tedious, I proceeded to examine the rectum, not caring to subject the patient to the shock that would follow the prolonged anæsthesia that would be necessary for the cervix operation. I discovered a constricted sphincter ani muscle, which, on dilatation, revealed two papillæ and four pockets, which were extirpated. As the removal of these abnormalities frequently exerts a powerful effect on the success of other surgical operations, I would advise a like procedure when operating under similar circumstances.

After this operation the patient made a rapid recovery, without any untoward symptoms, the wounds healing by first intention; the patient seemed to be somewhat improved in manner and appearance, but certainly no marked improvement resulted, and my daily visits constantly elicited the same discouraging reply, "I am no better;" and she really was no better, whatever improvement there was being entirely physical, the mind remaining in the same distressing state. I was compelled to perceive that the origin of this malady was not in the hypertrophied labia, nor the constricted clitoris, nor in the rectal abnormalities. I awaited, carefully observing the case for twelve weeks, before resorting to further surgical interference, during which time I prescribed such remedies as aurum, aconite, belladonna, can-

nabis Indica, helonias, hyoscyamus, nitric acid, pulsatilla, and anacardium. The latter, I felt sure, would improve the case, and continued it in varying potencies for several weeks; but none of the remedies produced any effect. I then advised the second operation, and the patient, in desperation, consented, without much hope of benefit.

On February 1, 1893, I performed the operation for the repair of the lacerated cervix according to the method of Prof. Pratt. As the technique of this method is somewhat different from that usually pursued, it will be well to describe it somewhat in detail. After introducing a Sims's speculum the cervix is grasped with volsellum forceps, thus bringing the uterus down and enabling the introduction of the guy ropes through the anterior and posterior walls. The cervical canal was then dilated, the endometrium curetted, and the cavity of the uterus packed twice with iodoform gauze which was removed on completion of the operation; then, with a pair of sharp-pointed scissors, the cervix is incised on each side to nearly the vaginal junction; then, with a scalpel marking off the canal, with a pair of curved scissors I removed *all* the cicatricial tissue from each of the four surfaces, finding it necessary, to accomplish this, to tunnel out on either side of the canal a plug of cicatricial tissue reaching entirely to the internal os. As the circular artery lies about one-sixteenth of an inch anterior to the internal os, great care was necessary to escape wounding this vessel; however, such an accident would not necessarily prove disastrous, but is a complication to be avoided when possible. After having shaped the four flaps so that they would approximate nicely, I used silver wire sutures, twisting the ends and causing the parts to come accurately into apposition with each other. I have since used silk-worm gut and perforated shot in a similar operation with perfect satisfaction. The patient recovered splendidly from this operation, not exhibiting any rise of temperature, and meeting with no complications. The first day after operation she felt a slight change in her mental condition for the better. The second day she expressed herself as having something to live for, before which she was constantly wishing to die. The third day everything appeared more natural; she wanted some one around to talk to and tell them how much better she felt. Husband and children appeared more natural, but not entirely so. The fourth day the improvement was marked.

In short, the patient continued to improve day by day, until one day about two weeks after the operation she looked out of the win-

dow and said it seemed like a new world to her, that she saw everything in its proper aspect again and was the happiest woman in the world. April 15, 1893, patient reports that her mental and physical condition is all that can be desired, she suffers from none of her previous (illusions) trouble.

I have reports of other cases in my own practice and in that of other physicians for whom I have operated, which abundantly confirm the great value of the orificial methods of treatment in cases which have resisted all internal medication and surgical operations not directed toward the lower orifices of the body, which, far more largely than the great majority of physicians believe, control the great sympathetic nervous system, and with it the functions of capillary circulation, assimilation, nutrition, and reflex nervous phenomena extending through the entire organism, and not merely at the points where the operations are performed.

This is practically a new field in conservative surgery, and is rapidly broadening, so that in orificial surgery we have reason to hope that in a very few years physicians will be able to successfully cope with many deep-seated affections in that dreadful category of mental and physical diseases so often encountered in practice, and which have heretofore, in very many cases, been universally recognized as hopelessly incurable.

OSSICULAR MASSAGE BY MEASURED VIBRATIONS IN DEAFNESS AND TINNITUS AURIUM.

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At the last meeting of the American Institute of Homœopathy in Washington, D. C., Dr. Garey, of Baltimore, presented a paper on the subject of the treatment of partial deafness and tinnitus aurium by means of massage applied in a natural way through the application of sound waves made to impinge with varying degrees of force and rapidity on the membrana tympani and through this to the ossicles. The article attracted considerable attention at the time, and was discussed at some length.

Having had considerable experience with several methods of

massage of the sound-conducting apparatus of the human ear, I have been greatly interested in Dr. Garey's experiments, and have followed him closely.

My attention was first called to this method of treatment, as I have already described in this journal, by reading Mr. J. A. Maloney's paper recounting his experiments with his so-called otophone (see *THE HAHNEMANNIAN*, July, 1890). Many good results followed the application of this method of aural "massage," but it failed in cases where it seemed quite well indicated.

Following this, Dr. Garey suggested the use of the Edison phonograph, with the aid of properly constructed cylinders for the application of other sounds than those of the human voice, which latter sound was the limit and extent of the use of the otophone. This proved, by experience, to be a step in the right direction, in some cases quite flattering results being obtained; but again disappointment confronted us, for very many cases still failed to yield to the mild blandishments of wizard Edison's erstwhile toy. The principal objection to the phonograph, and one which it was thought important to surmount, was the inability to procure any wide range of pitch thereon, and as Dr. Garey's theory was based largely on the importance of the application of the similar sound, that is the sound most nearly simulating the pitch of any existing tinnitus, it may readily be seen how important an obstacle was presented.

After considerable experimentation on the part of a skilled constructor of musical instruments under Dr. Garey's instruction and direction, the vibrometer was ultimately presented to the profession. An instrument designed and devised for the production of varied sounds of an infinite variety of pitch, and the conduction of the same to the ears of the patient.

A short description of the instrument and its methods of application will here perhaps be of importance.

As first placed before the profession it was comparatively crude, but as experience in its use has accumulated, numerous suggestions making improvements in the instrument have been submitted to and adopted by the company engaged in its manufacture; these are of a minor mechanical nature, but have added decidedly to the efficiency of the instrument.

Briefly, it now consists of a wooden case on a light truck or support, this case containing the instrument proper, viz., a banjo-shaped affair with a heavy neck fretted somewhat similarly to a guitar or banjo. The head or diaphragm of this quaint instrument is of thin

wood, and above or over the face of this head is erected a metal framework supporting a carriage, movable to and fro over the face of the instrument; this carriage conveys a shaft connected by a belt with a small electric motor. In the centre of the shaft is a "cam" or eccentric, which in revolving strikes the "central attachment" which in turn is connected by means of a lever with the diaphragm below, from which via of an air-tight space beneath this wooden head proceeds the rubber tubes to convey the sounds to the ear. At the upper end of the shaft is a small wheel armed with four small "pickers," which, as the shaft revolves and the carriage is lowered strikes as rapidly as we require the string selected for producing the tone or pitch desired. The instrument is equipped with four strings from a fine treble piano string to a heavy bass "cello" string. The space between the frets are lettered to facilitate the recording of pitch used at each setting. A small clamp is provided which can be screwed down on the strings at the desired point and held in place as long as desired.

The arrangement of the strings is such that the "pickers" can be made to strike two strings at once, thereby varying still farther the pitch possible of procurement. An effort will be made to have an improvement immediately added, in the form of a clamp, that will permit of the clamping of one or two strings simultaneously without necessarily clamping all four. This will permit of the production of harmonic tones, which will, it is believed, aid materially, especially in conditions of nervous deafness and tinnitus.

This, then, is the vibrometer, designed to produce many sounds of varied pitch and effect and their transmission to the membrana tympani and ossicles, thereby producing massage of these portions of the hearing apparatus, stimulating secretion and motion where rigidity exists, improving circulation, and in many cases, I believe, stimulating the perceptive tract to more natural response.

Much has been written, and many experiments have been made, on this line, showing that the profession, especially otologists, are interested. It matters not what means are used to produce the tones and pitches so long as they are properly produced and conveyed, and the principle of close study of each case presented is followed, in which event much can be done to aid many suffering beings.

The method of treatment, as applied by this instrument or any other, does not reach all cases. We have failures recorded as well as cures and partial cures, but I am not prepared to say these

failures are all due to the fact that the method is not adapted to these cases; failure often comes because we have not yet mastered it in its perfect application.

In applying the instrument to a given case, I expect prompt, good results if I find a hypertrophic, active, catarrhal condition of the pharynx and post-nasal space, with Eustachian tubes nearly or quite impervious, thickened and retracted membrana tympani, and some sclerosis, with ankylosis of the ossicles.

I expect less prompt and not quite as good results in proliferous catarrh, and lastly I have experienced many failures and few successes in those suffering with an atrophic catarrhal condition.

When the internal ear is seriously involved, I have always failed to get any appreciable good results. Where bone conduction is lost, or nearly so, I have found the treatment a failure.

It is my practice to inquire as to the exact effect on any existing tinnitus immediately after the first treatment. In some cases it has entirely ceased, in many it is much reduced, in a few it has been materially aggravated for a time, and I have known many where no immediate change whatever was noticeable.

So far as ultimate results are concerned, the fact of immediate aggravation seems to have little weight. A number of such cases, in my practice, have received a good measure of improvement.

To sum up, I would say, according to my experience, the otophone was *good*; it was a step in the right direction. The phonographic treatment was *better*, and up to date the application of massage to the sound-conducting apparatus, by means of the vibrometer, is *best*. Undoubtedly we will have improvements added to this method of application. Each investigator can and should add some practical ideas. For instance, Dr. A. B. Norton, of New York city, who is doing good work in this line, first suggested to me the advantage of adjusting the strings so that the pickers could strike two strings simultaneously, thereby vastly increasing our range of pitch.

For the benefit of any reader who may have the instrument as originally constructed, I will briefly recount the principal items of improvement:

First. The shaft carrying the "cam" and "picker" wheel can now be adjusted with one hand, the double-threaded screw arrangement being superseded by a single control-screw.

Second. The central attachment or "*thumper*," instead of rising above the shaft and curving over, is now entirely below the car-

riage, and consists of a metal post tipped with tough fibre, which is struck by the revolving "cam." The lower end of this post is connected at a right angle to a lever, the position of the fulcrum of which is movable by means of a small metal pin, which can be adjusted along its length at will. The distal end of this lever is in immediate contact with the diaphragm, and the vertical movements of this lever drive the diaphragm up and down as rapidly as we may desire, this motion being conveyed to the membrana tympani by the column of air between the vibrating diaphragm and the membrana tympani through the conducting tubes.

The present position of the post below the shaft enables the carriage to be swept across the face of the instrument to any desired position without the necessity, as heretofore, of detaching this central post.

Third. The fret spaces are lettered, and the strings numbered to facilitate recording the pitch applied at each treatment.

Fourth. The tuning-keys are an improved pattern, set firmly in the wood-work and held strongly in position by a nickel-plated metal face; this does away with the annoyance of loose keys, which have been a former source of worry. To give a brief idea of the character of the work, being done with the aid of the vibrometer, I herewith append a few cases taken from my office record-book:

Mrs. H. M. B., æt. 56, consulted me about her hearing and a tinnitus on January 24, 1893. History of long-standing deafness and tinnitus; has had the classical treatment without success. She has naso-pharyngeal, tubal and middle ear catarrh, proliferous stage. On the first test A. D. H. = $\frac{2}{60}$ A. S. H. = O. B. C. good. She was immediately placed under the influence of the vibrometer, and has continued, rather irregularly, at average intervals of seven days. Improvement has been steady and gradual as well as satisfactory to her, notwithstanding an acute attack of influenza and tonsillitis in February. On April 10, 1893, the occasion of her latest treatment, A. D. H. = $\frac{16}{60}$ A. S. H. = light contact. The tinnitus entirely gone. She is still under treatment.

Mrs. J. M. C., æt. 41; in general bad health, suffering from a species of nervous prostration. Hypertrophic catarrh of naso-pharynx, Eustachian tubes and tympanic cavity. Membrana tympani retracted, sclerosed, with undoubted ankylosis of the ossicles. Almost constant distressing tinnitus, aggravated by fatigue. She has had several sieges of the usual methods of treatment for such cases, in every instance followed by aggravation, until quite recently, when

she consulted one of the most celebrated aurists in the homœopathic profession, and she claimed to have received much benefit from him, though he held out little hope. First test, January 19, 1893. A. D. H. = $\frac{8}{50}$ A. S. H. = $\frac{5}{50}$. Treatment was begun with the vibrometer, together with inflations of ether vapor through the Eustachian tubes, and some attention to the naso-pharynx; this was continued at average intervals of four or five days. Condition, March 29, 1893: A. D. H. = $\frac{26}{50}$ A. S. H. = $\frac{15}{50}$. The tinnitus only annoys her now when tired and nervous. She has expressed her delight with the result, and states that her friends have all remarked the great change. She has ceased treatment for the present to go to her home in the West.

Mrs. C. R. D., æt. 46. November 14, 1892. A. D. H. = O. A. S. H. = O. History: Has been gradually getting deaf for a year or more, but in the past month has grown rapidly worse. Hypertrophic naso-pharyngeal catarrh, with involvement of tubes and tympanum. Four treatments with the vibrometer, with the usual attention to the nose and throat, produced the following result: December 5, 1892, A. D. H. = $\frac{20}{50}$ A. S. H. = $\frac{16}{50}$. At this point she ceased treatment, and has since reported that she appears to hear as well as ever. A very distressing tinnitus entirely disappeared after three applications.

Mrs. A. G. D., æt. 42. June 2, 1892. Consulted me regarding a considerable deafness and distressing tinnitus. History: Right ear now hears watch only on close contact; has been quite deaf for twelve or fourteen years, and has no hope of assistance for this ear. The left ear now hears the watch $\frac{4}{50}$, and has only been involved sufficiently to annoy her for a few months. This ear she hopes to have relieved. She is a fashionable modiste, and her affliction is so annoying to her that she threatens to give it up. She has a general hypertrophic catarrh of naso-pharynx and larynx, with tubal involvement, the tubes are impervious, the Ant. retracted and dry, with ankylosis of the ossicles. The tinnitus is terribly annoying and has "made her quite nervous." At this time the Edison phonograph was in use by me, and in this case it was applied twice a week for three months. October 7, 1892: A. D. H. = $\frac{8}{50}$ A. S. H. = $\frac{30}{50}$; the tinnitus is better, but a low, constant hum is still heard, and there remains much confusion and inability to catch words clearly in a conversation. Separate sounds seem to be heard quite readily, but spoken phrases are often misunderstood. On October 14, 1892, treatment with the vibrometer was substituted; treatment applied once a week. On

April 11, 1893, date of last treatment A. D. H. = $\frac{18}{50}$ A. S. H. $\frac{50}{50}$; almost no tinnitus, and no confusion for conversation, except when very tired and nervous.

M. C. F., æt. 46. Otitis media catarrhalis chronica. She complains of considerable deafness and an annoying tinnitus. On September 30, 1892, A. D. H. = $\frac{12}{50}$ = A. S. H. $\frac{1}{50}$. The phonograph was applied for one month with little or no resulting improvement. The vibrometer was then used and continued for five months; present record is A. D. H. = $\frac{45}{50}$, H. S. H., light contact. The tinnitus has been persistent and has only recently begun to subside. I cannot account for the slight loss of power in the left ear in the face of the material gain in the other. This result affords food for reflection and practical study.

It is but right that the other side, viz., complete or partial failure, should be reported; hence I will append a few failures, for purpose of comparison.

Judge J. S. P., æt. 58. Actively engaged on the bench of one of our courts. Is in good health and fair spirits, but considerably annoyed by a constant tinnitus, high pitched and persistent. It is apparently of nervous origin, for it is decidedly aggravated by mental work, with some attendant confusion in the left temporal region. Semi-weekly treatments with the vibrometer, from March 19th to April 15th, has produced no effect whatever. There is no deafness, and I have discontinued treatment by this means for the present.

Mrs. J. D. S., æt. 52. History of deafness in right ear for over ten years. A. D. H. = 0. In left ear for three years. A. S. H. = 0. The tinnitus is distracting, and she is becoming intensely nervous. Marked atrophic catarrh of the nasal cavity. Ant. retracted and tympanum dry. Treatments with the vibrometer and stimulating applications to the nose, throat, and tubes every five or six days, from October 22, 1892, to April 11, 1893, has produced no material change in the hearing power, and the tinnitus has only become slightly less marked within the past two weeks, this probably being largely due to the improved climatic conditions.

So far, the cases of absolute failure are few. In some cases, the gain made being slight and progress slow, the patient becomes discouraged, and gives up active treatment or becomes irregular in reporting. Many of these cases must be classed with the failures at present, though in some instances undoubtedly capable of material improvement if the treatment was faithfully persevered in. In the larger number of cases that present themselves I am convinced that

when study and individualization are resorted to, results will soon appear that will encourage both physician and patient to renewed effort.

It is of little or no avail that we simply look on this instrument as an accurate machine, and turn it on and let our patient receive its effects, hit or miss; each case that seems to present any hopeful aspects whatever should be studied, and the method applied as carefully as any other scientific effort toward the relief of human suffering or distress.

I have frequently been asked the question, "Are the results permanent where improvement is obtained?" I cannot, of course, answer that by actual experience, as my use of this instrument only dates back to October last, but I will say that in my experience, covering six years, all cases that have been materially improved by means of ossicular massage through sound vibrations, *however applied*, have retained that improvement to an almost entire degree.

To close, then, I am convinced that the method of treating this large class of sufferers by means of aural massage is a correct and scientific one; it only remains for us to find the suitable method in each case. At present, I believe the vibrometer is the very best medium at our hand, though perhaps still capable of much improvement.

Passive motion and massage of stiffened joints and tissues of the body is the accepted common-sense method now universally applied for their relief. In these cases we apply the same means through a different force, viz., vibrating force or sound, which is by nature adapted for treatment of like conditions existing in the delicate joints and tissues of the organ of audition.

DR. GEORGE A. HALL.

THE untimely death of our distinguished colleague, Dr. George A. Hall, of Chicago, which occurred April 4th, will touch the heart of the medical profession with sadness and regret. Called suddenly from the front ranks of his chosen calling, in the very prime of his fully-developed manhood, at a time when he was actively engaged in the arduous duties of his professional life, and his mind absorbed in projects and ambitions that must remain unfulfilled, his death is

an irreparable loss to the profession of which he was a conspicuous ornament, and to the community by which he was respected, honored, and loved.

Dr. Hall was a man of great force of character, deep in his convictions, having an unbounded faith in his own fertile resources, and possessed of an unswerving determination that overcame every obstacle and opposition in the performance of duty and in the achievement of his noble ambitions. To him all things were possible. Failure was an unwritten word upon the pages of his life.

The early influences of his life undoubtedly had much to do in developing these strong traits of mind and character. Born among the rock-clad hills of the Empire State,—his lot a farmer's lad,—the rugged surroundings of his boyhood home seem to have inspired him with a spirit of firmness and self-reliance that were to serve him well in the struggles and conflicts of life.

At an early age he displayed a fondness for books and an aptitude for teaching, and, at the age of fifteen, we find him at the head of a school of seventy pupils.

During all this time dreams of a collegiate education fired his imagination and stirred his ambitious soul, but, as is so often the case with aspiring and deserving youth, time and money failed him and he was obliged to abandon the coveted course at Yale University. At the age of seventeen he began the study of medicine in the office of Dr. L. M. Kenyon, of Westfield, N. Y., finishing the initial year of his work in the Berkshire Medical College. The following fall he entered Jefferson Medical College and, while a student there, became converted to the law of Hahnemann by observing the results of homœopathic remedies in severe cases of dysentery. This changed the plan of his medical course, and the ensuing year he graduated from the Homœopathic Medical College of Pennsylvania, now known as the Hahnemann Medical College of Philadelphia. After receiving his degree, Dr. Hall located at Westfield, the home of his birth and the scenes of his early struggles. Here, in the following year, he wooed and wed Miss Francis Sherman, who was his life-long companion, and who, in the last hours of his suffering, ministered to his comfort with a wife's tenderness and devotion. For sixteen years he practiced medicine in the quiet little village of Westfield, and, though restricted in many respects, it offered a fruitful field for the exercise of his charitable instincts. During the stormy days of the rebellion, many families of soldiers who were absent on the field of battle resided in the community; these he attended during the

continuance of the war, without charging, or even accepting a dollar of remuneration. In many instances he not only gave his professional services, but also supplied the unfortunate ones with necessities of life out of his own bounty. This generosity was always characteristic of the man.

But Westfield offered little scope for a nature so aggressive and talents so gifted, and, in the month of June, 1872, Dr. Hall moved to Chicago. From that time until his death he was closely identified with the growth and prosperity of the homœopathic profession throughout the great Northwest. In the autumn of 1872 he entered Hahnemann Medical College as instructor in surgical anatomy, and the following year was appointed Professor of Obstetrics and Diseases of Children. This chair he occupied with distinction till the memorable split in the faculty in 1876. This disruption of the faculty, which threatened the very existence of the institution, occurred at a time when the hospital was dilapidated and run down, the credit of the college crippled, and affairs in general presented a deplorable condition. In such a crisis Dr. Hall was made business manager of the college and superintendent of the hospital, and, with the faithful few that were left, faced the herculean task of reorganizing the faculty and re-establishing the college. Too much praise cannot be accorded the memory of Dr. Hall for his invaluable services and self-sacrificing spirit during this period of reconstruction. He was the Moses who led the disabled and disheartened college out of the wilderness of apparent utter ruin. At his own expense, he fitted up dormitory apartments for the accommodation of the students, refurnished the hospital, and established daily clinics for the first time, and became responsible for all the expenses and liabilities of the college.

During the first year he expended out of his own personal funds for the support and maintenance of the institution no less than four thousand dollars. Besides managing the business affairs of the college he showed his prodigious capacity for unremitting labor by lecturing upon obstetrics, diseases of children, and the whole field of surgery, and holding weekly clinics in all three of the branches. During these trying times in the history of the college Dr. Hall was truly a tower of strength—the mainstay of the institution—and until his retirement as an active member of the faculty, in 1889, he gave to the college the same loyal support, the same devoted and zealous service—always ready to sacrifice private interests for the welfare of the college he loved so well. From 1876 till his resig-

nation from the faculty, in 1889, he was Professor of the Principles and Practice of Surgery and Surgeon-in-Chief of the Hospital. His labor in these fields was prodigious and his success was phenomenal. During his connection with the institution it became the largest homœopathic medical college in the world. Such devoted service, however, naturally entailed great financial sacrifices, for his professional skill was eagerly sought far and near. In the spring of 1889 premonitions of an overworked constitution induced him to resign his professorship, which was a great strain upon his strength and health. But the warning was prophetic, and in the same year his wonderful vitality succumbed to what almost proved a fatal nervous prostration. After a long and weary illness his depleted powers revived sufficiently to enable him to go to the country life and bracing air of the mountains where a summer's sojourn restored him to health. In January, 1892, he resumed the active duties of his profession, and labored uninterruptedly to the time of his death. His strong love for the college for which he had done so much overcame his former resolution, and he took up the department of orificial surgery, making it one of the most interesting features of the college course. At the time of his death he had all but completed his *Surgery*, which was to be the culmination of his life's work. The last chapter remains unfulfilled—typical of the sudden termination of his noble life.

Dr. Hall's position in the medical profession was one of rare eminence. As a surgeon he had few peers. He was a brilliant though conservative operator, original in his methods, and combining a most accurate judgment with a thorough knowledge of the entire field of surgical science. His practice was very extensive, and his professional opinion and skill were always in demand. His fees were high, and this confined his *clientele* largely to the better class of people, though his charity knew no bounds. As a professor Dr. Hall was at his best. He was a born teacher, possessing in the highest degree the power of imparting knowledge to others. He was the most popular of instructors. His clear, earnest manner always carried conviction, and his magnetic personality, his forceful style of speaking always commanded the closest attention of his audience. He possessed a keen sense of humor, but his wit was always clean and wholesome. Few men could be as caustic as he; his tongue was a free lance to error, narrowness and fraud. He hated hypocrisy; he loved truth, liberality and honor. Outside of his didactic lectures, Dr. Hall's literary work was confined chiefly

to medical journals and magazines. His contributions to these were voluminous and valuable. His writings were clear and concise and pregnant with practical and useful knowledge.

The last work that engaged the attention and energetic support of Dr. Hall was the organization of the World's Fair Homœopathic Hospital, of which he was the prime mover. His last appearance in public was at a meeting of the board of directors, of which he was the honored president. Thus, his final effort in life was for the welfare of the profession for the advancement of which he had given a life of faithful service. In effecting the completion of this worthy enterprise his wise counsel and foresight, his remarkable executive ability and tireless energy will be greatly missed, but the temple of homœopathy he was so instrumental in rearing will be a fitting tribute to his fidelity to the true interests of the profession, to his skill and high attainments as a physician, to his gentleness and charity for mankind, and to his purity and nobility of character.

After a month of intense but patient suffering, borne with courage and with hopefulness, tired nature at last gave way, and the gentle spirit of a noble soul winged its flight to the mystic realms of eternity.

W. S. HARVEY, M.D.

ALOPECIA PREMATURA: ITS MOST FREQUENT CAUSE ECZEMA SEBORRHOICUM.—Dr. George T. Elliot from a study of 234 cases of alopecia prematura, draws the following conclusions:

1. Constitutional and systemic conditions may be causative of alopecia prematura, but only in a great minority of the cases which come under observation.
2. The overwhelming majority are due to the local processes which are known as pityriasis capitis, alopecia pityrodes, seborrhœa sicca, and the higher grades to which these may progress by increase in the inflammatory symptoms.
3. All of these severally described forms of disease are merely stages and grades of the process known to-day as the eczema seborrhoicum of Unna.
4. The proof of this is seen clinically in the progression and transformation of the slighter grades into the higher, the evolution of one stage to another not being exceptional, but almost always the rule in any given case.
5. Microscopically, it was found that from the slightest to the highest grade, the pathological phenomena were represented by degrees of inflammation of the skin, superficially situated in the former, but extending more or less throughout the entire cutis in the latter. As a result of the inflammatory process, there was a hyperformation of horny epidermis.
6. The sebaceous glands were found unchanged, the diminution in the amount of their secretion being due to mechanical interference to its egress, not to disturbed function.
7. The source of the squamæ seen in the various stages is the hyperplastic epidermis, not the sebaceous glands.
8. In consequence of the processes being inflammatory in nature and situated in the cutis and not in the glands, in consequence of the squamæ being epidermic and not glandular in origin, therefore the inclusion of these processes among glandular diseases of the skin and the designation of seborrhœa attached to them are manifestly erroneous.—*N. Y. Medical Journal*, February 4, 1893.

EDITORIAL.

THE PRIZE ESSAY ON HOMŒOPATHY.

"Truth crushed to earth will rise again—
The eternal years of God are hers;
While Error wounded writhes in pain,
And dies amidst his worshippers."—BRYANT.

ABOUT one year ago, Dr. George M. Gould, editor of the *Medical News* of Philadelphia, in a lecture or address delivered before a graduating class in a Buffalo medical college, announced that he would give a prize of one hundred dollars for the best essay showing the ridiculous pretensions of modern homœopathy. The successful essay he proposed should be used for circulation among the laity, thus killing homœopathy by one tremendous blow. Dr. Gould's munificent offer was announced in every allopathic journal in the land. If we mistake not, homœopathic journals also assisted in disseminating the news of his liberality.

On January 1, 1893, the essays were all in and competition was closed. The committee examined thirteen essays, and unanimously decided in favor of one by Dr. William W. Browning, of Brooklyn.

And then there was silence. What had become of the essay? Eagerly we scanned the pages of the *News* and other allopathic journals week after week. We had almost feared that the essay had been suppressed, when lo and behold, a firm of homœopathic pharmacists rescues it from oblivion by putting it on sale over their counters. Nowhere do we hear of any old-school doctors using it as a campaign document; no allopathic journals announce it with flourishes of trumpets or shouts of approval. It is simply purchased by the homœopaths as a means of innocent amusement, as they would buy *Puck*, *Judge*, *Life*, or other comic papers. This sounds strange, but truth is often stranger than fiction.

The much talked of essay bears on its title-page a well-known verse of Bryant,—the one that heads this editorial. We fail to see its appropriateness to Dr. Browning's essay. We fail to see that his school of medicine has been "crushed."

On page 2 of the cover we are told that to this essay was awarded "the prize of one hundred dollars offered by Dr. George M. Gould, of Philadelphia, and is designed for distribution by physicians in

order to disseminate more enlightened views upon the subject of which it treats. Copies of the pamphlet may be ordered of Dr. George M. Gould, 119 South Seventeenth Street, Philadelphia, at the rate of seventy-five cents per dozen."

In both places in which Dr. Gould's name is mentioned, it is printed in small caps. For an essay designed for distribution among the masses, page 2 of cover and facing first page of essay, makes a first-class advertisement. We are not sure that the essay itself may prove a valuable source of income at the price named; that is, if homœopaths keep on buying it in the quantities they are at present doing.

The essay consists of a communication of thirty-one octavo pages and a preface. The latter is chiefly of importance for its very candid statement to the effect that "regular" physicians cannot be expected to make an experimental test of homœopathy, and because it gives the bibliography on which the essay was founded. As might be expected, this is not very extensive. It consists of the *Organon*, Boericke and Tafel's *Medical Index*, Allen's *Encyclopædia*, three pharmacopœias, two essays on homœopathy by its enemies, and the notorious article on homœopathy in the ninth edition of the *Encyclopædia Britannica*. We can offer no criticism to the *Organon* as an authority. We fail to see the use of the pharmaceutical works. As to the symptomatology of Allen's *Encyclopædia*, Dr. Browning says nothing that has not been more ably stated by homœopaths themselves. The Hooker, Smythe, and *Britannica* essays are, of course, bad authorities.

The essay itself opens with historical notes, rather remarkable for incorrectness than for anything else. This same fault is to be found with many other portions of the work. Indeed, it seems to be the author's object to erect structures in order to destroy them, rather than to attack the homœopathy of the present day. He certainly fails to grasp the proper idea concerning the dynamic origin of disease, this theory providing not for a spiritual origin of disease, but rather for constitutional conditions or peculiarities of the individual by reason of which external causes become operative. The most advanced minds of the dominant school, as represented by Sir Andrew Clarke and Jonathan Hutchinson, have given their adherence to this view.

Dr. Browning's statement of the homœopathic platform is nearly correct. He states the following propositions as the result of a study of the *Organon*: 1. That *similia similibus curantur* is the only thera-

peutic law. 2. That drugs must be prescribed on the totality of the symptoms. 3. The only true method of learning drug effects is by experimentation on the healthy. The only exception to the above that we can make is in the first proposition. Hahnemann never claimed *similia* as the only therapeutic law, for he distinctly stated instances in which it was not applicable.

One idea of the essayist seems to be to belittle Hahnemann as much as possible. We think that here he attempts to prove too much. He reminds us very much of a certain lawyer, who, in defending a damage suit, showed by some witnesses that the plaintiff was always sick before his injuries, and had been always well since receiving them. Dr. Browning first shows that homœopathy antedated Hahnemann by ages, and was recognized by the old school, and then endeavors to prove that there is nothing whatsoever in the homœopathic principle. He detracts from Hahnemann and gives the credit of homœopathy to Hippocrates and Celsus. That both of these classical authorities knew of the not infrequent application of the homœopathic principle, is universally acknowledged by our school. To Hahnemann belongs the credit and honor of placing our therapeutic law on a sound basis, and so systematizing *materia medica* as to make it a practical art.

Page 4 starts in with a defence of the author's school of medicine. He objects to the title *allopath* as inappropriate. He does not advance any new argument here, nor does he prove that the allopathic school should bear any title than the one objected to, for he shows plainly between the lines that notwithstanding a professed liberality of sentiment, anything savoring of homœopathy is carefully tabooed.

On page 5 he very properly warns his readers not to confuse isopathy and homœopathy. The distinction between the two he says: "is, however, almost too refined for the ordinary mind to grasp."

Following closely upon the remark just quoted is the statement that "the modern homœopathist in the presence of alarming diseases, abandons his theory of similars and falls back upon the scientific discoveries of rational medicine." Let us ask what are the scientific discoveries of rational medicine so far as they relate to drug action and its practical application? Does modern allopathic medicine provide any reliable clinical data concerning the use of drugs in disease? To answer this question, one has only to consult the latest old school works on the practice of medicine, namely, those

by Osler and Pepper, and he finds, aside from quinine in malarial troubles, iodide of potassium and mercury in syphilitic affections, there is actually no reliable therapeutic fact in the whole domain of "modern scientific medicine." To the practical physician, such modern scientific methods afford but little comfort in the battle with disease. We are fully aware that many of our school do resort to so-called allopathic measures in many cases. This was ably shown in the attack upon homœopathy published by Dr. S. O. L. Potter some two years ago; but Great Heavens! what allopathic prescriptions! If Dr. Browning wishes to claim *such* therapeutic nonsense to prove the truth of his own doctrines he is welcome to them. We do not condemn our men for resorting to these measures; we blame their originators, the allopathic empyricists. How any sane individual, be he allopathic or homœopathic could possibly have expected any beneficial influence from such measures is inconceivable to us!

Dr. Browning gives some instances of what he thinks should be homœopathic action. He says: "Opium will control pain. Quinine will reduce fever. Alcohol and ammonia will relieve faintness. Now, if similia be a law, opium ought to cause pain in the healthy; quinine, fever; alcohol, faintness, etc.; but this is not the case." Here he is wrong. Opium does produce pain, as witness such a phenomenon in opium habitues; and opium will *cure some* cases of pain. Dr. Browning, however, only refers to the use of opium as a universal palliative, which use is well condemned by the majority of "modern scientific" physicians. Quinine is universally acknowledged as unable to control fever other than malarial intermittent; it produces fever of that type. Alcohol will produce faintness as witness "the difference in the morning" after a night's stimulation.

Says the essayist: "Homœopathy does not attack disease, but addresses itself to the amelioration or removal of the symptoms attendant upon it." Homœopathy does attack diseased conditions but in their totality, and not by a given generic name. The same is the ambition of "modern scientific medicine." Practically, however, allopathic therapeutics seem only to have reached that point where palliation only is obtainable, as witness the teaching of the modern works on practice of medicine.

Dr. Browning's idea of the "totality of the symptoms" is altogether wrong. Let him construe the term literally, and let him remember that Hahnemann defined the totality as consisting of all objective and subjective symptoms. That to-day we are able to dis-

cern objective conditions which were unknown in Hahnemann's time does not militate against the correctness of the latter's teaching in the least. Our school has advanced with scientific research. That some of our men play the fanatic and decry all advancement is unfortunately true of us ; but is equally applicable to the Rip-Van-Winkles of the allopathic persuasion.

"To discover the cause of disease has ever been the task of the rational physician," says our essayist, who states confidently that the cause has been discovered. Herein we differ. No one attached more importance to ætiology in its relation to cure than did Hahnemann. Notwithstanding the remarkable advances in medical science, very little relating to the intrinsic causes of disease has been learned.

Hahnemann was never an enemy of pathology. He did, however, express his opinions concerning the pathological doctrines of his day in an unequivocal manner. The pathology he condemned is now regarded as useless ; we might even speak more strongly, and say that modern scientific allopaths criticize ancient pathological doctrines more severely even than did Hahnemann. The latter even stated that when pathology became an exact science, then would it prove of practical value to the physician.

Dr. Browning's remarks concerning the elements necessary to drug proving are in accord with the principles enunciated by the American Institute of Homœopathy. He uses Allen's *Encyclopædia* as the standard text-book of our school, of which he says : "What little there is of value in it, however, lies buried under such a mass of trash as to be entirely inaccessible ; for indiscriminately mingled with the legitimate effects of drugs are sensations experienced long after they have been eliminated from the system ; those attributed to inappreciable doses and those due to circumstances entirely independent of the medicine." Is not this the position assumed by our own school towards Allen's *Encyclopædia* ?

Next we have several pages devoted to the high potency question, one that has been discussed and rediscussed until it has thoroughly disgusted nearly every man interested in it. Dr. Browning simply proves himself a fair arithmetician and apt at figures ; nothing more.

Now, we come to something amusing. Homœopathy is credited with using snakes, toads, bugs, bacilli, and morbid products, as standard remedies. It is true that we use the virus of certain animals as the honey-bee, and the lachesis trigonocephalus as remedies. It is not true that we do use many disgusting remedies. The nosodes have not been accepted by us, excepting such as have been

thoroughly proven and their effects studied carefully. What has allopathic literature to say in this respect? In the first place, we learn that chronic rheumatism has been cured by the sting of a bee. This testifies to the virtues of *apis mellifica* as an anti-rheumatic. We learn that an eminent allopath has been experimenting for years, and still persists in the employment of testicular juice as the panacea for all ills; and this, notwithstanding the serious and oftentimes fatal results attending its employment by his confreres. We learn that an eminent bacteriologist discovered a pseudo-cure for tuberculosis, which cure drove the medical world so near crazy that there was almost a general pilgrimage to Berlin. Thousands of invalids perished on the altar of this great discovery. Was not this remedy disgusting in the eyes of Dr. Browning? And again, the illustrious Dr. Hammond has discovered a new "pathy" which has not yet become epidemic. He proposes to feed nervous invalids on an extract of brain matter, and suggests the possibility of curing many diseases by the administration of extracts of the appropriate organ. Think of that, O, reader, for modern scientific rational medicine! Stewed kidney for Bright's disease, fried liver for biliousness, chicken's heart for chicken-heartedness, etc., etc.!

Next comes a consideration of the dissensions among homœopaths. Differences of opinion exist, but they do not amount to dissension. The same is true to far greater extent of the allopathic profession. Let any disinterested party read the standard literature of the day, and the differences in views respecting important topics will fairly bewilder him. We almost fear that it will drive him from medical men entirely.

The statement that Hahnemann failed to recognize the *vis medicatrix nature* is false.

Now, there follows a lot of unimportant matter consisting of laymen's talk which has no bearing on the argument.

We come to the following statement: "Teachers in medical colleges sometimes advise certain of the candidates for graduation, if they persist in practicing medicine, to adopt homœopathy." What a confession! Said teachers graduate incompetent men, and advise them to practice homœopathy lest they harm the public! Let us say that teachers of that kind should be put in the penitentiary at once, and that it is Dr. Browning's bounden duty to expose them at once.

The essay closes with sophistries and inaccuracies of statement, of which that relating to the Ward's Island Hospital is by no means the least.

We might speak at much greater length concerning the "Gould Prize Essay," but space forbids. We must confess ourselves disappointed in it. We had expected a much stronger argument. It certainly does not compare favorably with preceding efforts of other allopaths. If a competition open to over a quarter of a million of physicians can produce nothing better than this, homœopathy is indeed strong!

THE CHICAGO CONGRESS.

ALL roads lead to Chicago. The homœopathic pilgrimage is due May 28th, to be ready for the World's Congress of Homœopathic Physicians and Surgeons, from May 29 to June 3, 1893. Drs. Mitchell and Dunn have everything in readiness, and success is assured as far as the Chicago Committee can make the Congress a success. The balance depends upon the acceptance of individual responsibility by the profession. The indications at present point to the largest assemblage of homœopathic physicians in the world's history. The sectional work promises splendid results. The Sections of Clinical Medicine, Surgery, Gynæcology, Pædology, etc., have long been completed, and are represented by many of the ablest writers in medicine and surgery of the day.

There seems to be a widespread idea that the hotels and boarding-houses of Chicago are going to rob visitors by charging excessive and exorbitant rates. This is entirely without foundation. The Chicago Committee assures the members of the profession that the Chicago hotels have not raised their regular rates for the Exposition period, and they further state that board can be obtained at almost any rate desired according to accommodation. The committee is leaving no stone unturned to have everything entirely satisfactory to the members of the Congress and their friends, and Dr. C. E. Fisher, not content with creating one of the ablest, brightest, and most progressive medical journals in existence to-day, irrespective of schools, is going to outdo Fisher by issuing a daily edition of the *Medical Century*; the same to contain from twelve to twenty pages daily, of uniform size with the regular edition of the journal. This edition will be sent to subscribers, who cannot be in attendance upon the Congress, at a cost of seventy-five cents. This is journalistic enterprise indeed, and while the propriety of securing all the addresses in advance by the *Century* is to be questioned, the HAHNE-MANNIAN thoroughly appreciates the enthusiastic undertaking of the brilliant editor, and wishes the *Century* continued and prolonged success.

GLEANINGS.

GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D., AND FRANK H. PRITCHARD, M.D.

BORAX IN PARALYSIS AGITANS.—Prof. Grasset, of Montpellier, France, claims borax to have a decidedly sedative effect upon paralysis agitans. It palliates in a striking manner, some of the symptoms of this disease, above all the trembling. This drug has long been known as possessing sedative powers (sal sedative), and on this account it has been employed in epilepsy. Three grammes of the drug are given daily, without any bad results, in powders of five grammes each. As in both schools there is not a remedy that seems to have any effect upon this disease, this contribution is certainly acceptable.—*La Semaine Medicale*, No. 3, 1893.

THE STOMACH IN THE MORPHINE HABIT.—Dr. F. Plessner, of Wiesbaden, confirms the statement of Hitzig, that in consequence of the drug being secreted through the kidneys in morphine habitués, the quantity of gastric juice is reduced to possibly nearly nothing, and acidity, and the phenomena during abstinence are thus rendered more violent. In about sixteen cases under treatment he prescribed muriatic acid to overcome this condition and with good results, in nearly all cases; bad taste, nausea, regurgitation and peculiar pressure in the region of the stomach yielded. The appetite increased to such an extent that the patients would eat three times as much as before treatment. This action is of the greatest importance as strong and nourishing food, with frequent changes are the best aid to breaking off the habit. The acid was used until the slightest trace of these symptoms was to be observed; usually they would disappear within three days. Only in one case did this method fail him, and that in a patient who had suffered in 1888 from a gastric ulcer and contracted the morphine habit in consequence. He was also a user of enormous daily doses of cocaine (30 grains) and who had made four vain attempts to shake off the habit. During the period of reduction of the dose (four weeks), the gastric symptoms were very slight, the appetite excellent and the increase in weight fifteen pounds. But during the first three days of entire abstinence the gastric symptoms were so severe that a recurrence of the old ulcer was feared. These gradually decreased, and after a treatment of eleven and one-half weeks he was discharged with an increase in weight of twenty pounds. In all these cases, even in the first days after the final injection, the gastric symptoms were very slight; this he ascribed to the acid.—*Berliner Klinische Wochenschrift*, No. 9, 1893.

TREATMENT OF TOOTHACHE BY STATIC ELECTRICITY.—Dr. Gatchkovsky has discovered that the "electric breeze" is an admirable calmative agent in odontalgia. The brush is placed over the aching tooth and the patient placed upon an insulated chair, as in the administration of static electricity. Curiously enough, he has found this current to exercise a sedative effect not only upon nervous toothache, but also those of inflammatory origin and due to a pulpitis or periostitis. The pain begins to diminish in two or three, to disappear completely within five or six, minutes. The pain may return, but it will be less intense and yield to a few sittings of at least ten minutes' duration. Under the influence of this current the gums become manifestly pale at the time that the toothache disappears. He has employed it in seventy-five cases, with but three failures.—*La Semaine Médicale*, No. 8, 1893.

TINCTURE OF SUN FLOWER IN MALARIAL FEVER IN CHILDREN.—Prof. Moncorvo, of Rio de Janeiro, Brazil, has experimented with sun flower in malarial fever in children. The drug has long been known to the Russian peasants as possessing antimalaric virtues. He gave from 1–10 grams of an alcoholic tincture, in a potion, a dose every two hours; he also used an alcoholic extract. It was well

tolerated by even the very youngest, it being administered, in all, to 61 children, with a successful result in the majority. It was fully as active and prompt as quinine. One case was of evident gravity—*Le Bulletin Médical*, No. 4, 1893.

ACUTE LEUCÆMIA.—Dr. G. Nobl, of Vienna, observed two cases of this affection. The most characteristic symptoms are an ulcerative stomatitis, which, in a few days, develops into an extensive gangrenous destruction of the gums, buccal mucous membrane and lower lips, and a hæmorrhagic diathesis. The stomatitis generally is the first symptom of the disease, and on account of the gangrenous complication in 70 per cent. of all cases, it is of capital importance in the development of the disease. This is the starting for the assumedly infectious process; the lymphatic glands, spleen and liver enlarge, and the affection progresses. The hæmorrhagic diathesis is observed as subcutaneous and submucous hæmorrhages. Hæmaturia may set in early and lead one to suspect hæmorrhagic purpura, as it may begin with a splenic enlargement and leucocytosis of the blood. Hyperplasia of the hæmatopoetic organs is not so pronounced as in chronic leucæmia. Generally, only the cervical and submaxillary glands enlarge and sometimes develop into true lymphomas. The hepatic and splenic increase is not immoderate. The blood cells undergo rapid and characteristic changes. The leucocytes increase in number in a very short time, and reach a state that in chronic leucæmia would require months and even years; 10 — 1 : 1 is a frequent finding. Large medullary cells are found and are characteristic.—*Wiener Med. Presse*, No. 50, 1893.

SCARLET FEVER IN ADULTS.—Dr. Gimmel, of Zurich, Switzerland, found out of 1818 cases of scarlet fever appearing in that city from 1881 to 1889, 15.08 per cent. have been among adults. They were generally observed in thickly inhabited districts, or houses where children had been previously attacked. In general, the predisposition is less than in children. The disease runs a less violent course; nephritis is rarer, and, when observed, less severe. Articular complications, on the contrary, are more frequent and still not grave.—*Münch. Med. Wochenschrift*, No. 3, 1893.

DIAGNOSIS OF MUMPS.—Prof. Comby finds mumps confoundable with pre-auricular adenopathy, tonsillitis or inflammatory parotiditis.

Pre-auricular adenitis has the same seat as the mumps but it is more superficial, limited and if one gland only be involved it is easily outlined. When the surrounding cellular tissue is involved there is a phlegmonous plaque, hard, very painful and soon replaced by fluctuation; often the disease affects several glands and it may be continued into those of the neck. It is generally unilateral.

Certain cases of tonsillitis are accompanied by a voluminous glandular enlargement situated at the angle of the jaws and simulating the measles. The throat symptoms will suffice here to make the diagnosis. Sometimes the glandular manifestations may be ill-defined when a secondary complication may clear up the case. True inflammation of the parotid gland, either primary, as from cold, or secondary, as in infectious diseases has the following characteristics: It is nearly always one-sided, does not undergo metastasis nor does it jump from one side to the other. It presents a hard, tender and extensive swelling which may terminate with suppuration, gangrene, etc. At the prodromic period a diagnosis is impossible, for one may think typhoid fever threatening from the depression, headache, epistaxis, etc. Acute gastric catarrh from the saburral state of the tongue or any of the eruptive fevers before their eruptive period. When the swelling sets in one may think of scarlatinous angina with cervical adenopathy or diphtheria but the absence of eruption, in the first case and of false membranes, in the second will decide. In lead poisoning, after systemic impregnation the parotid glands take on an indolent and soft tumefaction; it is essentially chronic and permanent. The iodides may produce double swelling of the parotids, with coryza, salivation, œdema of the eyelids. The diagnosis is difficult in masked forms, in cases where the order of development is reversed or where the localizations are unusual. When the mumps involve the submaxillary gland the case will usually be diagnosticated as adenitis rather than mumps but the suddenness and symmetry of the swelling, its greater softness than hardness in consistence, its form and seat corresponding to the submaxillary gland as well as the evolution of the disease, will aid in deciding. When the disease attacks the sublingual glands the case is still more difficult, for one will have to decide between an acute ranula and a phlegmon of the floor of the mouth. The ab-

normal cases are most frequently those not diagnosticated. The mumps when involving the testicles attack the testicle itself while gonorrhœa involves the epididymus. Small-pox, typhoid fever, and other infectious diseases attack the testicles; these former grow to suppuration while that of mumps does not. Grave nervous symptoms, convulsions, delirium, stupor, opisthotonos would indicate a meningitis, but the appearance of a parotiditis or orchitis would clear up the diagnosis.—*Le Bulletin Médical*, No. 8, 1893.

ENLARGEMENTS OF THE SPLEEN IN CHILDREN.—Dr. Kuther divides splenic enlargements in children, into acute and chronic. The patient is placed in the so-called diagonal position, i.e., half way between the dorsal and right lateral position. Acute enlargement is observed in the new-born in certain infectious diseases, as typhoid, recurrent and intermittent fever, acute miliary tuberculosis, meningitis pneumonia and sometimes in infarcts of the spleen, scurvy, hereditary syphilis, general tuberculosis, icterus, local tuberculosis of various regions, splenitis and in blood diseases in consequence of absorption of pus, blood, products of inflammation, in vaccination fever, inflammation of the lymphatic vein, and inflammation of the cellular tissue, etc. In certain infectious diseases as scarlet fever, measles and acute infantile diseases, a latent splenic tumor is often present and yet not due to the disease. Chronic splenic tumors due to cirrhotic processes of the liver are rare in children. Those from general venous stasis of heart and lung disease are more frequent. In rachitic children the spleen is often found enlarged as well as in congenital syphilis. A certain diagnosis can only be made by palpation.—*Wiener Medizinische Presse*, No. 9, 1893.

PROGNOSIS OF CHRONIC ALBUMINURIA.—Dr. Ralfe finds the most common form to be that of interstitial nephritis, accompanied by its usual cardio-vascular symptoms. From its insidious beginning this affection is often not recognized until such grave symptoms as albuminuric retinitis, dyspnœa, hæmorrhages from the mucous membranes and paralyses have set in. Then the chances of prolonging the patient's life are indeed small. In gouty nephritis the intensity of the diathetic manifestations governs the development of the renal affection; when these improve, the renal disease may become essentially chronic. Certain symptoms, dropsy, and uræmia, etc., do not have the same importance as in other chronic albuminurias and often disappear, an acute gouty attack appearing. In syphilitic subjects the outlook is bad on account of vascular degenerations setting in early. When once well developed they rarely survive eighteen months. In gouty subjects one often observes a chronic hæmorrhagic nephritis, as well as paroxysmal or intermittent nephritis; true renal gout, another form, is remarked and observed in middle-aged individuals who are inclined to obesity; it is probably from venous plethora and associated with a slight degree of diabetes. The albuminuria of morphine eaters owes its origin to a probable venous stasis from paralysis of the venous veins. Milk diet is indicated in acute and subacute nephritis: it combats the dropsy. In the advanced stages of chronic nephritis it is not well tolerated, especially if there be extensive vascular degeneration or uterine symptoms. In one of his cases uterine symptoms would develop every time he tried to institute a milk diet. In youthful patients albuminuria may appear from slight causes. Its appearance in those over forty is of grave import. In scanty and very albuminous urine a milk diet is of service. Intermittent albuminuria may produce a rapid deterioration of the health within a very few years. In gouty nephritis the quantity of albumin may be but slight "traces" and yet the symptoms be menacing. Albuminuria may also be associated with chronic malarial poisoning. Profound anæmia aggravates the prognosis.—*La Semaine Médicale*, No. 14, 1893.

CAMPHORATED OIL IN CARDIAC PARALYSIS.—Dr. L. Gaussia has used camphorated oil in several cases of collapse from threatening heart failure during influenza, in pneumonia, typhoid fever, etc., with satisfactory results. The vehicle was oil of sweet almonds, with the ethereal tincture of peppermint as a corrigent. He prescribed large doses, 2 to 4 grammes (30 to 60 drops) of a 1-5:100 solution, per diem. This was well borne, and never produced any disagreeable symptoms. One should not wait until the patient is in extremis, but prescribe it when a stimulant or expectorant is indicated, provided no cerebral irritation is present. In cases of pneumonia, broncho-pneumonia, and typhoid fever, it raised the arterial pressure, improved and eased the expectoration, and gave the patients a lasting feeling of ease. He advises one to use only Japanese camphor, as the artificial preparation is of no therapeutic value.—*Medicinische Neuigkeiten*, No. 7, 1893.

GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D.

AMPUTATION AT THE HIP-JOINT.—Senn (Chicago), adds another to the recent modifications in the direction of bloodless amputation at the hip.

The patient is drawn down so that the pelvis rests on the edge of the table. This enables an assistant to change the position of the thigh without difficulty.

Langenbeck's incision for resection of the hip is made and lengthened downward to about eight inches. The knife is kept in contact with the bone from the tip of the trochanter downward. The wound edges are retracted and bleeding points are picked up.

The trochanteric muscular attachments are successively separated, the thigh flexed, adducted, and rotated inward, when the capsule is opened posteriorly, its division being completed with the thigh in a flexed position. The ligamentum teres is severed after outward rotation, or, failing in this, the head of the bone is forcibly dislocated backward by flexion, adduction, and inward rotation.

The trochanter minor and the upper part of the shaft are cleared with the scalpel or the periosteal elevator, according as it is desired to save the periosteum or not. The bone can then be pushed through the wound and cleared to any extent desired.

With the thigh flexed and in a line with the body, and with the bone protruding from the wound, a stout hæmostat is pushed through the tissues downward and inward behind the adductors, until its point is felt and exposed by a skin incision. The instrument starts on a level with the trochanter minor, when in its normal position, and comes out two inches below the ramus of the ischium.

A piece of rubber tubing about four feet long and three-quarters of an inch in diameter (or, on a pinch, a bandage or a cord of gauze) is grasped by the forceps in the middle, drawn through the opening, and cut in two.

After rendering the limb bloodless by the Esmarch or Lister method, the anterior segment of the thigh is constricted with one-half of the tubing; the posterior is similarly treated with the other half of the tubing, the ends of which are then brought around to include the whole limb.

Flaps are made from the skin and superficial and deep fascia, by circular section or by oval incisions giving long anterior and short posterior (or *vice versa*), or internal and external flaps. The muscles are divided transversely over the portion of the bone previously cleared.

The divided vessels and nerves are treated in the ordinary manner and the wound closed. The loss of blood is slight and the method is particularly adapted to emergencies, very little assistance being necessary.—*Chicago Clinical Review*.

GASTROENTEROSTOMY IN TWO STAGES.—Postnikow (Moscow), proposes a modification in the technique of intestinal anastomosis by which the completion of the communicating opening is delayed until firm serous union has taken place.

1. The serosa of an intestinal loop is fastened to the stomach by a line of sutures.

2. Close to this an oval piece is cut out of the stomach and intestine, leaving the mucosa intact.

3. The posterior edges of these two openings are united.

4. The bulging mucous membrane of the stomach and intestine are successively drawn out of the oval opening, a ligature thrown around it and tied. By sloughing, which takes place on the third or fourth day, the anastomotic opening is made.

5. The suture of the edges of the oval openings is completed.

6. Step one is continued until the serosa of the intestine is attached to that of the stomach all around the seat of operation.

The escape of the intestinal contents is prevented by this method and absolute asepsis rendered possible. The necessity for a preliminary washing out of the stomach, a measure which weakens the patient, is done away with. There is no danger of intestinal leakage as firm union has taken place by the time the mucosa sloughs. Eighteen or 20 interrupted stitches, or a continuous suture applied at considerable intervals will suffice; much valuable time is saved in this way.

The claims of the procedure, which is suggested as a modification to gastro-enterostomy but can be applied to any portion of the intestinal canal, are based upon 17 experiments on dogs; they were uniformly successful, the animals taking nourishment at the end of 24 hours. There was no hæmorrhage when the mucous membrane came away, and no subsequent stenosis was observed, the animals being killed at the end of from six to 13 weeks.—*Centralblatt für Chirurgie*.

INTESTINAL RESECTION FOR MALIGNANT DISEASE—Dr. Lowson (Hull, England) reports a case of unusually extensive bowel excision, the cæcum, the greater part of the ascending colon, and five inches of the ileum being removed.

The patient, seven years before, had received an injury to the right side of the abdomen. About a year before bowel hæmorrhages took place, and, three months before, a tumor was noticed in the right loin. The abdomen was opened on the outer side of the rectus, and a large mass involving the colon was found. To free the tumor it became necessary to remove the ascending colon and the last five inches of the ileum. The peritonæum was divided at the base of the meso-colon and mesentery on the outer side of the colon and the lower side of the ileum. The opposite side was then divided after the peritonæum and vessels had been tied in sections. Several diseased glands were also removed. Makin's clamps were applied to the ileum and hepatic flexure, the bowel divided, and the intestine and tumor removed. The divided bowel ends were invaginated and closed by mucous and serous rows of stitches, and an anastomosis made by means of Senn's decalcified bone plates. The abdomen was cleansed, closed, and drained.

The patient rallied from very serious relapse and made a good recovery, rapidly gaining in weight and strength. The serous surfaces about the anastomotic openings were not scarified, nor was the bowel anchored near the abdominal wound; but particular attention was paid to uniting the diverging layers of the mesentery at its junction with the bowel.—*Lancet*.

TREATMENT OF FRACTURES OF THE PATELLA.—Klemm (Riga, Russia) has used the following method with gratifying results during the past five years:

The knee and adjacent portions of the limb are at once massaged, especial care being taken to rub *from* the fracture, in every direction, to aid the removal of the extravasation by the vessels and lymphatics. The joint is then wrapped in cotton batting, which is covered by a figure-eight of surgeon's adhesive plaster so applied as to exercise a moderate degree of pressure on the joint, and hold the fragments in coaptation. The limb is then elevated on a posterior splint. This dressing is removed in two or three days and massage again practised, being particularly applied to the anterior femoral muscles. The articulation and muscles are then rubbed daily, until, at the end of two weeks, slight passive motion is made, and the patient is instructed to attempt to elevate the limb while the knee is held in extension. In from three to four weeks the patient is able, in most instances, to walk about the room with the aid of a cane, and, in from five to six weeks, is in condition to be discharged.

The results were very satisfactory; osseous union was obtained in no case, but a strong, firm, fibrous bridge formed between the fragments, which did not interfere with the action of the joint; every case had the power of complete, active extension, with flexion to fifty degrees when discharged; in no case was there atrophy of the quadriceps or cicatricial formations in or about the joint. The "bloody suture" is warned against, and this method is particularly recommended as it can be used by any one with a little care and patience.—*Medizinische Neuigkeiten*.

Johnson (Baltimore) reports two cases of compound, comminuted stellate fracture of the patella treated without suture. In one, the parts were carefully cleansed, three pieces of bone removed, the cavity allowed to fill with blood, and the outer wound closed with silk sutures. Protective, iodoform, and sublimate gauze, a posterior splint, and an ice-bag, were applied, the dressings being changed at the end of a week. In three weeks the patient was discharged with a healed and useful joint. In the other similar case, the ligamentum patellæ was united to the bone, from which it had been separated, with a strong silk suture, the comminuted fragments removed, and the wound similarly treated. The dressings were changed in two weeks, and the patient allowed to go about in a splint. He was discharged at the end of ten weeks with a slightly movable joint, the stiffness gradually yielding to passive motion.—*Annals of Surgery*.

GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D. AND J. NICHOLAS MITCHELL, M.D.

ATROPHY OF THE UTERUS IN YOUNG WOMEN.—Gottschalk devotes a monograph to this important subject. Without doubt, atrophy of the uterus is often the direct or indirect result of scarlet fever, typhoid fever, and acute articular rheumatism. The uterus may be directly involved, though ovarian disease, if very severe or very chronic, usually involves uterine atrophy. He particularly notes that in four of his cases the patients were attacked by typhoid fever at the time of their first menstruation. The lesson drawn is that tonic treatment should be continued long after the disappearance of the fever. The return of strength is then usually followed by a reappearance of the period. — *The Archives of Gynecology*, November, 1892.

SYMPHYSIOTOMY.—A pelvic diameter of $2\frac{1}{4}$ inches is a safe minimum limit for the operation. The safe average separation of the seat of operation is $2\frac{1}{2}$ inches. The method of performing the operation, after the part has been shaved and everything made aseptic: A catheter is introduced, by which the urethra is depressed and carried to the right. Then a vertical incision is made about $2\frac{1}{2}$ or 3 inches through the skin and fat, going to the left in order to avoid the clitoris, detaching the muscles for a short space; introduce the finger and separate the tissues behind the bone, and locate the finger (left hand) on the inferior margin of the articulation. Then, introducing the knife (Galbaitis'), cut from within outward and upward. Care must be observed during the passage of the child to keep the parts covered. As Dr. Ernest W. Cushing, of Boston, says:

"It is a solemn thought that of 84,000 already overloaded obstetric bags in this country, a very large proportion is to be enriched by the acquisition of a hooked knife for symphysiotomy, a weapon that will prove a sickle of death unless guided by intelligence, environed by cleanliness and illuminated by anatomical knowledge. Like any other operation, pubic section is easy and safe enough for a surgeon who is clean and careful, and whose patient is in a reasonably good condition; but the incision goes near important organs—the urethra, the bladder and the peritonæum; it passes where there may be hæmorrhage from arterial branches, which must be looked for and controlled; it lays open important cellular spaces, which must be kept clean, and it severs the key to the ring of the pelvic bones, so that care must be taken that no undue violence is done in the subsequent delivery. If attention is given to these facts, the new operation promises to be a splendid advance in our art—a means of rescuing great numbers of women sinking under the throes of prolonged and hopeless labor, and of saving the lives of innumerable innocent infants now permitted to perish undelivered or sacrificed in the stern choice between losing two lives or taking one."—*The Homœopathic Journal of Obstetrics*, January, 1893.

FIBROUS UTERI.—At a meeting of the British Gynæcological Society, Mr. Christopher Martin presented a specimen which confirmed what Mr. Lawson Tait had previously insisted on, viz.: that in cases of large multinodular myoma where there was violent hæmorrhage a small polypus was often found in the uterine cavity, and this was the source and cause of the hæmorrhage. The suggestion that in every case, before opening the abdomen, before doing hysterectomy or removing the appendages for myoma, the cervix should be dilated and the uterus explored for a polypus is absurd. In the majority of cases the myomatous masses so surround the canal that to dilate the cervix is highly dangerous. He had had a case which amply proved this. The patient had a myoma which was believed to be submucous, if not polypoid. It was deemed advisable to dilate to explore, but the process of dilatation immediately brought on an attack of acute peritonitis, and the patient nearly died. The lesson learned was that it was by no means safe to dilate the cervix in a myomatous uterus. Dr. Haywood Smith said that Dr. Bantock had also exhibited fibrous uteri having polypi growing from the fundus. Dr. R. T. Smith remarked that if the polypus in the uterus was from four to six inches above the cervix, there was no means of removing it at such a distance; so its presence was no argument against hysterectomy.—*The British Gynæcological Journal*, November, 1892.

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY
CHAS. M. THOMAS, M.D.

TYMPANIC OTALGIA; TREATMENT.—It is known that neuralgia of the tympanum, particularly the chronic form, often resists all our methods of anti-neuralgic treatment. Now, according to Dr. E. Max, assistant at the General Polyclinic of Vienna, an excellent means of combating those cases of tympanic otalgia consists in making, on the external apophysis of the malleus, a certain number of successive pressions or vibrations.

For this purpose the ear speculum is introduced, and, with the aid of the frontal mirror, the short apophysis of the malleus is exposed to view; then a metal probe, curved at an obtuse angle, about 8 centimetres (3½ inches) long, and with its bulb wrapped in cotton, is slid along the superior wall of the auditory canal, without, however, touching the wall. With the probe held between the thumb and index finger, five to ten gentle pressions or vibrations are made, in more or less rapid succession, on the external process of the malleus.

This manœuvre often produces a little hissing or tingling in the ear. Repeated daily, it first causes, it is reported, a diminution of the frequency and of the intensity of the neuralgic attacks, then their complete disappearance; practiced at the very moment of an otalgic attack, it will arrest it nicely. It is stated that it also exerts a very beneficial influence on the headache (frontal, temporal, or occipital) which often accompanies tympanic otalgias.

In Dr. Max's cases the duration of the treatment varied according as the affection was more or less recent. Thus, in the otalgias that were not of more than two weeks' standing, a few days of treatment and sometimes even a single seance sufficed for a cure; while the more inveterate cases, dating several months back, required as much as four weeks of treatment.—*Merck's Bulletin*.

OCULAR OPERATIONS PERFORMED IN THE OPHTHALMIC SERVICE OF THE VENETIAN HOSPITAL.—M. Gossetti analyzes four hundred and eighty-eight operations, and the following *résumé* contains the most important points:

Cataract.—The author has never abandoned the superior corneal section, combined with iridectomy. Among one hundred operations, only one panophthalmitis developed, and that was in a young woman who had serious renal disease. According to this author, real antisepsis is not possible in ocular surgery, inasmuch as the solutions which ought to be used would be much too strong and too irritating for the eye. He uses a sublimate solution (1 to 3000) which he thinks quite strong enough for an antiseptic. (It is much stronger than necessary.—EDS.) Intra-ocular irrigations are a complication of the operation, and the author declares himself opposed to their application.

Total Staphyloma.—He practices resection of the staphyloma at its base, not followed by a suture. The bandage is changed after five days, but the eye is not opened until the seventh or tenth day.

Sympathetic Ophthalmitis.—There is one remarkable observation of a boy of 8 years attacked with serious sympathetic ophthalmitis, soon followed by cyclitis. A subconjunctival injection of sublimate and another made twelve days later controlled the disease. In consequence of imprudence, there was a relapse, which was controlled by a third injection.

OBSERVATIONS ON THE MACULA LUTEA.—Johnson (*Arch. of Ophth.*, xxi., 1) has arrived at the following conclusions: 1. When observed in a certain way, the macular ring in its entire circumference can be seen in every person under thirty-five years of age, and frequently, though with diminishing frequency, over that age. If the source of illumination be gradually lowered, the reflection from the fundus decreases more rapidly than that from the margin of the macula, so that a period arrives when more light is reflected from the latter than from the general fundus, and at that moment the ring appears. 2. The macula is invariably circular, and probably corresponds to the extreme limit of the macular region. 3. The ring is without doubt due to the cup-shaped dip of the macula. Seeing the ring in almost every person, and being thereby able to determine the limit of the macular region, it may prove of practical value in diagnosing whether a lesion or defect is situated within or without the region of acute vision.

MONTHLY RETROSPECT OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D., AND FRANK H. PRITCHARD, M.D.

APIS IN DIARRHŒA.—One or more thin and loose stools immediately on rising in the morning. Many years ago I called attention to this symptom as diagnostic to some extent of ovaritis. The same or similar symptom, either pathogenetic or clinical, has been observed in relation to *actea*, *aloe*, *arsenicum*, *bryonia*, *dioscorea*, *lilium*, *podophyllum*, *rumex* and *sulphur*.—Dr. A. C. Clifton, in the *Monthly Homœopathic Review*, March, 1893.

GASTRIC PECULIARITIES OF ANTIMONIUM CRUDUM.—The most marked features are the intensely white and somewhat coated tongue, with much slimy mucus in the mouth and throat, together with loss of appetite, desire for acids, nausea, faint sensation in the stomach. Wine or other alcoholic beverages, if given, cause aggravation, occasionally painful flatulent distension in the abdomen; the urine is generally normal, but the action of the bowels is irregular, constipation alternating with diarrhœa. This group of symptoms, under the nomenclature of atonic dyspepsia, I have generally cured quickly by antimonium in the 6x trituration.—*Ibid.*

ACTION OF ANTIMONIUM CRUDUM ON THE SKIN AND THE NAILS.—Here, hard papular eruptions, itching when warm in bed, as well as pustular eruptions, general dryness of the skin, especially the soles of the feet, which are hard and horny, yet tender and painful when walking; corns on the feet, brittleness and splitting of the finger-nails; these symptoms are largely characteristic in connection with other manifestations of ill health. Warts on any part of the body I have seldom, if ever, seen cured with this medicine.—*Ibid.*

TARTAR EMETIC IN RELATION TO THE MENTAL STATE, THE SENSORIUM AND THE HEAD.—Here the most marked symptoms are the despondency and cryable mood, fear of being alone, sometimes followed by frivolous humor, or by anger. In severe cases of pneumonia, muttering delirium and stupor is characteristic of this medicine. The vertigo is like that of antimonium crudum, but with more confusion and dulness of the intellect, and with less nausea and faintness; while in relation to the head, a band-like feeling over the forehead is very pronounced.—*Ibid.*

GASTRIC SYMPTOMS OF TARTAR EMETIC.—Although the tongue may be somewhat white and dry, like as under antimonium crudum, it is generally red and dry, especially in the centre, very similar to the tongue of *veratrum viride*, but with much less soreness and smarting sensation than the tongue of *veratrum viride*. Difficult deglutition of liquids is a marked symptom, more intense nausea, retching and vomiting, especially after food, and with more deathly faint sensations and prostration than from antimonium crudum, and differing, moreover, in this respect from *ipecac*, which has more mucus and bilious vomit with less vertigo and prostration.—*Ibid.*

THE TISSUE REMEDIES IN DYSPEPSIA.—*Calcarea Phos.*—Where in dyspepsia there is a great deal of pain in the stomach which is relieved only temporarily by the belching of gas this remedy may do more good than either *carbo veg.* or *china*, which have the same symptom. It is said to be almost an infallible remedy for the collection of gas in the stomach. This flatulence and pain comes on after eating, and there is usually an unnatural hunger and perhaps a craving for salt.

Calcarea Fluor.—This remedy has vomiting of undigested food like all of the *calcarea*s, but otherwise its symptoms are not marked.

Calcareo Sulph.—Nor has *calcareo sulph.* any marked gastric symptoms, except a desire for fruit, tea and coffee. The appetite and thirst are increased.

Ferrum Phos.—This is an excellent remedy for an acute attack of indigestion where after taking food there is a flushed face and a great deal of pain, and where the stomach is so sensitive that the patient cannot retain the least quantity of food. Food causes nausea and there is a persistent vomiting of undigested food, which is very sour. All eructations taste of the food, and there is loss of appetite and an especial disgust for milk. These symptoms are accompanied by a headache, disturbed sleep, and a diarrhoea.

Kali Mur.—This is one of the best of these remedies for dyspepsia, and a white-coated tongue is a strong indication for it. If the trouble is brought on by over-indulgence in rich and fatty food, accompanied by a sluggishness of the liver, with loss of appetite and obstinate constipation and the white tongue, one can hardly go amiss in prescribing it. There is usually pain in the epigastric region, going through to the back or right shoulder, a jaundiced color to the skin, bitter taste in the mouth, and oftentimes vomiting of a glairy mucus, which will suggest its similarity to *nux vomica*.

Kali Phos.—This remedy corresponds to that condition known as nervous dyspepsia, where there is a weak, gone feeling in the stomach, where the patient is hungry soon after taking food, and where there is much flatulence which presses on and causes distress about the heart, as under *carbo veg.* and *lycopodium*. In indigestion with great nervous depression, where the patient is languid and exhausted, it will be the remedy.

Kali Sulph.—This remedy presents some similarity to *pulsatilla*. There is a yellow-coated tongue and a sensation of a load or fulness in the stomach, constipation, not much thirst, and the pain is very deep-seated. There may be some burning, however, in which case there will likely be thirst, nausea, and vomiting. Sometimes there is a gathering of water in the mouth as under *kali mur.* and *natrum mur.*

Magnesia Phos.—This remedy is indicated in the painful variety of dyspepsia, where there are sharp, griping pains at the pit of the stomach. There is excessive flatulence, and the belching of it does not give much relief. The eructations are burning and tasteless, and there is a disposition to regurgitation of food immediately after eating. There is a sensation about the epigastrium as if a band were laced about the body. The patient is averse to taking coffee. It is a very useful remedy in flatulent dyspepsia with nausea and vomiting.

Natrum Mur.—Indigestion with vomiting of clear mucus and heavy fulness and aching in the gastric region. There is distension and pressure in the stomach with longing for salt and strong-tasting things. There is marked aversion to bread, a sour taste, sour regurgitation of food and soreness in the pit of the stomach on pressing on it. A weak, sinking feeling at the stomach is also characteristic.

Natrum Phos.—Acid dyspepsia is met by this remedy. There is acidity, sour risings, and a loss of appetite, and it is often caused by fatty food. There is a great deal of flatulence and water-brash, and the tongue is coated yellowish at the base. Severe pain or burning in the stomach which comes on after eating and continues until the next meal is characteristic, especially if the pain develops about two hours after eating. There is an empty, gone feeling in the stomach, and when vomiting is present it is excessively sour.

Natrum Sulph.—Here we have a very bitter taste in the morning and the stomach feels distended and heavy. There is a constant nausea, sour eructations, heartburn and excessive flatulence, which is aggravated by any farinaceous food. Eructations of gas which is bitter or tasteless; complexion very sallow.

Silicea.—This drug is not often indicated in dyspepsia. It has a few symptoms reminding one of *calcareo*, such as ravenous appetite, sour eructations, etc. There is also an aversion to warm, cooked food, with desire for cold food.—Dr. W. A. Dewey, in the *Medical Century*, January, 1893.

THE MENTAL AND NERVOUS DISTURBANCES OF CHRONIC ERGOTISM —Prof. W. v. Bechterew, of Kasan, Russia, and his assistant, Dr. Reformatzki, have examined eighty nine cases of ergotism with reference to the neuropsychic disturbances. The phenomena sometimes appeared on the same day that the head containing ergot was eaten, especially when it was consumed hot and in large quantities, but the patients generally remarked them after one, two, or three weeks. At first there was a feeling of weakness, headache, vertigo, roaring in the ears, sleepiness,

vomiting, diarrhoea, colic, a disagreeable sensation in the region of the heart, formication and drawing in the limbs, amaurosis, sometimes complete transient blindness. If the disease had reached development then ergot spasms occupied the foreground, the hands and feet were chiefly attacked. During these cramps the patients complained of violent pains; in the intervals there were clonic twitchings, tremblings and fibrillary jerkings. Often not only the muscles of the extremities but also those of the face, abdomen and back were seized with spasms, during which the body would be bent forwards, backwards, or laterally. Dyspnoea would sometimes set in from spasm of the laryngeal and respiratory muscles. The tonic cramps, especially those of the extremities lasted for weeks and even months. During the attacks the rectal temperature varied between 36.5 and 37.8° C. In the course of time epileptoid spasms would set in, with loss of consciousness, though not in all cases. After the seizure the patients would fall into a sleep from which they would awaken with a feeling of depression, vertigo and indistinct vision. In other cases they remained for some time in a stupor. In some cases vertigo and loss of consciousness were observed. Again, cases of temporary unconsciousness, with local spasms and automatic movements were remarked. Some suffered from intense hallucinations of vision and hearing. In the course of a few or a series of attacks a mental disturbance, in the form of a stupid condition, would set in, which would persist for a few hours to weeks. In the majority of the cases the course was chronic. In some the disease recurred several times after apparent recovery and where a repetition of the poisoning could be excluded. Some patients complained, after a seeming recovery of mental weakness, slowness of thought and disturbances of memory. Among the physical disturbances are: anæmia, dilatation of the stomach, retention of urine and erections. The gait would be unsteady, with the presence of Romberg's phenomenon; in sixty-two out of eighty-two cases the patellar reflex was absent completely. In numerous cases the other reflexes were not to be brought out. In women the menses were disturbed. In many, sensation, temperature and touch were affected. In nine cases examination of the brain revealed hyperæmia and hæmorrhages of the membranes; in some cases between the pia and arachnoid of the cord there was a quantity of a caseous substance. In the substance of the brain, in many cases there were spots of softening, punctate and also more extensive hæmorrhages. Microscopic examination revealed, in the posterior columns of three out of five cases more or less pronounced degeneration.—*Wiener Med. Presse*, No. 5, 1893.

EXPERIMENTS WITH THE OXIDE OF ZINC.—Dr. L. d'Amore, of Naples, has experimented with the oxide of zinc upon dogs, giving it in doses of one-half to one gramme per diem. Death set in from ten to twelve days after beginning the experiments. The animals presented the following symptoms: Repeated vomiting, without apparent effort, extreme weakness, incomplete loss of sensation, very pronounced emaciation; diminution of the quantity of urine, hæmoglobinuria, albuminuria and glycosuria, hypoglobulæmia and leucocytosis; diminution of the hæmoglobine. Zinc was easily found to be present both in the blood and urine. The tissue changes found at the necropsy are of two kinds: lesions of vascular origin and those due to various degenerative processes. They may coexist in the organs, with more or less predominance of the one or the other, depending upon the time and the parenchymatous resistance to the drug. In general, it may be said that zinc, in its action is similar to that of phosphorus and arsenic. The chief points of attack are the blood, kidneys and general nutrition, i.e., the liver and pancreas, where as well as in the kidneys fatty degeneration is found. Possibly there is a certain relation between the pancreatic changes and the glycosuria.—*Revue Homœopathique Belge*, No. 9, 1892.

A CASE OF PULMONARY GANGRENE.—Dr. A. Fornica-Corsè, of Montevideo, S. A., was called to see Senora R., a widow of some sixty years, had had diabetes, and as a complication she had had an attack of pneumonia which had been succeeded by pulmonary gangrene. She was debilitated, pulse slow and weak, the mucous membranes notably pale as well as the skin; respiration difficult, the expired air being of an extraordinary fetidity and the sputa muco-purulent and blackish. There was lack of appetite and insomnia. *Arsenicum* 3x and *phosphorus* 12x were given. The first day no apparent change, the next day, when *carbo veg.* 12x, was substituted for phosphorus and alternated with *arsenicum*. Under the influence of these remedies the temperature which was very low rose, respiration and expectoration became

easier and more profuse, the fetidity of the sputa decreased as well as that of the respiration. In two days her appetite returned, and she asked for bread to eat, which she had not done for two months past. This food, together with grapes, were allowed her, and she improved rapidly. In six days she could walk about the yard, and in twenty-one days she was entirely cured. On auscultation the gangrenous foci are found cicatrized and the patient's strength, appetite, spirits and sleep are normal. Since then a year has elapsed, and though she has some diabetic symptoms, the pulmonary gangrene has not reappeared. *Carbo veg.* and *arsenicum* are the remedies which produced the result.—*Boletín de Homeopatía*, No. 2, 1893.

INFLUENZA.—The editor of the *Homöopathische Monatsblätter*, No. 1, 1893, calls attention to the virtue of *natrum nitricum*, instead of *aconite*, in the treatment of the pyrexia of the grippe as well as to *sabadilla* in this disease. If a chronic catarrhal disturbance persist after recovery *kali carbonicum* will be of service. Tartar emetic in moderately low potencies will be found useful in obstinate catarrhal sequelæ.

NOTES ON HYPERICUM.—In a paper on this subject, read before the Hughes Medical Club by Dr. E. P. Colby, the nervous symptoms of the drug were especially referred to. The author said that in his hands hypericum had been beneficial in neuritis caused by exposure to cold, by traumatism, and in the allied varieties of neuritis. It has also been useful in neuralgia confined to a single nerve trunk and its distribution, more particularly the sciatic. In this malady its only competitor is tartar emetic. It was of great benefit in a case of moniliform neuroma, with consequent neuritis, rendering the whole hand useless and very painful. Hypericum was the only internal remedy administered, and after three weeks' use the tumors on the nerve trunks could scarcely be found. The neuritis had also perceptibly diminished.

Hypericum is also to be thought of whenever, in the course of a nerve or in the area of its distribution, there is a burning tingling pain, with numbness and a glossy skin, particularly if there be an area of smooth mottled skin and occasional vesiculæ or bullæ. Its action on the peripheral nerves should entitle it to a trial in zona.—*N. E. Medical Gazette*, March, 1893.

CLINICAL USE OF PSORINUM.—Dr. A. L. Monroe deprecates the neglect of this valuable medicinal agent. He says that this drug symptomatically gives us an intensified and aggravated picture of sulphur. In its symptomatology we have the torpidity and lack of reaction, the glandular enlargement and induration, the eruptive tendencies in the skin, meeting besides increased offensiveness of all discharges, increased mental and physical depression, and decreased reactive powers. Thus it is very useful in the treatment of sickly infants with glandular enlargements, torpid eruptions, and offensive excretions.

The sulphur secretions are acrid and excoriating but not necessarily offensive, the psorinum secretions are all of these, and besides are always offensive in the extreme, even offensive to putridity.

The drug is invaluable in the treatment of infantile diarrhœa; the discharges are frequent, profuse, always offensive, and accompanied by emaciation and debility. Here it often follows china which has identical symptoms without the additional indications "after well chosen remedies fail to act," indicating the defective reaction that runs throughout the pathogenesis of the drug. These diarrhœas are accompanied by profuse offensive sweats, covering the whole body. The whole child smells badly.

The author has also found psorinum useful in eruptions that seem to call for sulphur, but which that remedy fails to cure. These eruptions appear preferably in the poor, the sluggish, the great "unwashed."

With children the psorinum condition is apt to be accompanied by enlarged and indurated glands, that tend neither to suppurate nor to get smaller.

In the adults when psorinum is indicated, there is generally present depression of mind, not the erethistic melancholy of hyoscyamus or the uncompromising despair of sepia, platina or calcarea carb., but a sort of abject uncomplaining, perfectly resigned despair of better things; showing a mental apathy and lack of resilience that entirely conforms to all of the drug's physical characteristics.

With these symptoms the drug is called for in tardy convalescence from typhoid fever or pneumonia, where the prostration and lack of reaction is out of all proportion to the violence of the symptoms or the duration of the disease, showing some latent dyscrasia to be present that is antagonizing the moral forces of nature.—*Southern Journal of Homœopathy*, February, 1893.

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SURGICAL SHOCK.

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(Read before the Congress of Homœopathic Physicians and Surgeons, Chicago, June, 1893.)

THANKS to anæsthesia and antisepsis, pain and poison have been eliminated from operative surgery, and the most formidable complication now remaining for the surgeon to cope with is shock. Its paramount importance, and the meagreness of the writings on the subject, make its further study eminently advisable. As here considered, the subject has nothing to do with "railroad spine," or "litigation symptoms," but is to deal with the immediate constitutional phenomena produced by local traumatism, and will be used synonymously with collapse. It will not be understood by this that shock cannot be produced by psychic as well as traumatic influences. The inter-dependence of the mind and body is shown by the influences of impressions that fall upon the retina from without. Let a patient who is to be operated gaze upon an elaborate array of instruments, and in some cases the effect is most pronounced. Through the mind, the knees quake with terror, the hair stands on end, the brain reels, the heart beats tumultuously, the respiratory apparatus stammers and gasps, the perspiration oozes from every pore, the urine is voided or suppressed—in fact any of these organs may be transiently disturbed or even paralyzed. These are familiar illus-

trations, but serve to show that psychical disturbance may act powerfully upon our physical being, and who can tell (and I ask it in all charity and kindness) how much this had to do with the death of Col. Shepard?

The above examples would seem to indicate that, turn and twist it how we will, we cannot escape from the fact that the mind is a power within our muscular being (Muller), or that the psychical and physical are practically one, and that the normal status of our grosser structures is more or less dependent upon the mind as well as the heart and lungs. Although shock of this variety may be profound, it is not necessarily surgical, but the varieties which are the accompaniment of visible trauma, and especially if co-incident or subsequent to surgical operation, are of special interest to us. Because the symptoms of shock are so familiar, they may, wisely, be omitted; on the other hand, its pathology is so obscure that it demands further study. The most advanced work on surgery takes up surgical shock and dismisses the subject of its pathology with the statement that it consists of paralysis of the vaso-motor system. Other works, devoting several pages to the pathology, add nothing to the above except what is conjectural. We know that, peripherally, the capillary resistance is diminished; so, too, is the motive-power of the cardiac centres. If the vaso-motor supply be cut off from one part of the body, the vessels therein dilate, but in a few days recover their tone; although future contraction and expansion is dependent upon local stimuli. The abdominal vessels may or may not be dilated. Further than this everything at present lies beyond the range of human perception. We may say that, in shock there is a disturbance in the molecular equilibrium which can no longer liberate force, but this is of little satisfaction to the analytical mind. Autopsies teach us nothing of the pathology; no post mortem traces ever having been discovered. The whispering of molecular vibrations which constitute human agony is lost in the roar of hurrying dissolution.

The clinical phenomena, however, corroborate the vaso-motor theory and the consequent relaxed vascular system. It is borne out especially by the intense thirst and the incredible quantities of water that many of these patients drink during profound collapse.

CASE I.—Removal of four and one-half inches of rectum for epithelioma. The operation was tedious but not very bloody, only two vessels being ligated. The operation was completed and the patient, in the most profound collapse, was placed in bed. The pulse was but an occasional flicker, the respiration faint; features pinched and

ghastly, pupils dilated. The ears and supra-sternal fossa were filled with cold sweat, and the body and limbs wet and cold. Hypodermic stimulation brought about little or no improvement and, as there was fortunately, no vomiting, I decided to try stimulating fluids by the stomach. Brandy and hot water was administered; at first, a few drops at a time, but it was soon given freely when it was perceived that deglutition was unimpaired. Suffice it to say that during that night he drank nearly five quarts of the liquid, though much of the time too weak to do more than turn his eyes appealingly towards the glass. He rallied the next day, the temperature not running above normal. In such cases the desideratum seems to be to give the relaxed vascular system something to contract upon.

The proneness of intestinal lesions to produce shock is worthy of attention, and so is the deception in its manifestations, especially during the period preceding dissolution. It is characterized by cessation of pain and sometimes vomiting—both of which may have been persistent—and the patient becomes perfectly easy and rational and the temperature may be normal. This is augural of collapse which is precipitated by operation.

CASE II.—I was called hurriedly to the suburbs and went prepared to operate for suspected intestinal obstruction. Found the patient able to sit up, feeling perfectly comfortable and having a normal temperature. The history as well as condition upon examination corroborated the tentative diagnosis and after giving the family a most guarded prognosis the patient was hastily prepared for operation. The abdomen was quickly opened and a quantity of dark brownish fluid came to view and instantly the patient was collapsed. The pulse was lost and the respiration consisted of an occasional gurgling in the throat. Inversion and subcutaneous stimulation were quickly resorted to. A hasty examination of the abdomen revealed a twist in the small intestines, lying in the left hypochondrium. Below this the gut was collapsed and above it, markedly distended and five or six feet of it black and gangrenous. Holding the intestines in with hot sponges we placed her in a warm bed and surrounded her with artificial heat and continued the stimulation; the abdominal wall being sutured in the meantime. She rallied slowly, only to die seven hours later and another death was registered—hastened by operation—and yet preventable by earlier interference. Here life is unstable and the slightest molestation is sufficient to destroy the equilibrium, but humanity prompts us to attempt to aid while yet the fingers of our surgical instincts are palpitating the lean possibilities that lie beneath the abdominal wall.

Before going further I wish to wring the neck of a moss-grown delusion. There has been much teaching to the effect that surgical shock is in proportion to the extent of the injury received. This is not true; the extent of the injury is no standard by which to estimate the intensity of the shock. It has been said that "shock is the measure of the ability of an individual to resist hurtful influences from without." In a general way this is good, but it is far more likely that it is *a measure of the power of resistance possessed by certain organs or structures.*

CASE III. will illustrate my meaning. A female about 40, with a hydatid cyst of the liver, as large as a cocoanut. Being incapacitated for household duties she desired an operation. The abdomen was opened freely, but the cyst was non-removable (*en mass*), because firmly adherent in all directions save toward the line of incision. The intestines were pushed aside and a passage to the tumor maintained by a firm packing of iodoform gauze. In spite of the rather free handling of the abdominal contents (because of a desire to extirpate if possible) there was little or no shock following the operation. During the next few days her general condition improved, and when sufficient time had elapsed to allow the bowels to be walled off firmly the cyst was opened, and this simple procedure was followed by the most pronounced disturbance of all the vital functions. The pulse was a mere thread and running one hundred and seventy-six to the minute, and vomiting was quite troublesome. It was evident that her life was gravely imperilled, and I was quite doubtful as to the issue. A pint of hot black coffee in the rectum and hypodermic injections of twenty minims of digitalis tincture brought the pulse down, in two hours, to one hundred and twenty to the minute. She was then complaining of the strong taste of the coffee, and was tided over the danger of the hour.

CASE IV. is even more suggestive. Mrs. G., æt. 51, suffering from a large ovarian cyst. The abdomen was opened and the tumor, weighing fifty-five pounds, removed. There was no post-operative shock, and she laughed and joked with the return of consciousness. A few days later an enema of warm water was given, by a competent nurse, and was promptly followed by profound shock. It was a very good picture of Travers's "prostration with excitement." She tossed wildly, the respirations were quick and shallow, pulse lost in one wrist, and flickering in the other, skin clammy and cold. She complained of nothing definite, but the face was expressive of indescribable anguish. Arsenicum 3x was administered and aided by sharp stimulation, she made a good recovery.

There was a suspicious flabbiness about this patient that I did not like, and on this account the operative work was conducted with all possible dispatch in order to avert shock. The significant fact, however, is that she could withstand a laparotomy but not a rectal injection.

The examples showing that the extent of the injury is not in proportion to the shock might be easily multiplied. Opening a digital abscess has produced death; a slight blow upon the testicle or epigastrium will result in alarming depression of all the vital forces. I have seen simple skin plantation for an ulcer of the leg followed by severe shock from which the patient did not recover for forty-eight hours.

In one particular, shock has not been sufficiently dwelt upon, either by writers, teachers, or operators, and that is, that sudden cessation of life in an individual does not of necessity mean cessation of cellular life in the tissues. This is a legitimate conclusion, and is based upon investigations in physiological chemistry and corroborated by observations in natural history and by the experiences of surgical clinicians. We may say that, grossly, the animal life is extinct, but histologically there is yet life and function in the tissues. This is shown by the fact that muscle removed from an animal killed suddenly will, for some time, give off carbon-dioxide, absorb oxygen, and respond to electric stimuli. Even after *rigor mortis* has occurred, tremblings, elongations, and contractions have been observed. After cross section of a tadpole, the tail will not only live for some time, but will actually grow if allowed to remain in the water (Vulpian). For more than twenty-four hours after removal from the animal, the pancreas continues its fermentation and the liver also produces sugar slowly after death. Surgeons know that ends of fingers severed and left upon the block have been sent for and made to live and grow upon their stumps, and that skin from recent corpses has been successfully grafted upon the living.

How often have we seen, upon the operating-table, extinction of life which would be eternal were the surgeon to turn his back to the patient; and how often the operation resolves itself into a question, not of obtaining primary union, removing the tumor, or preventing a hernia, but of saving a human life.

Now if the cellular structures of the grosser muscles and glands thus continue their function, so must the histological elements of the heart-muscle, or the respiratory apparatus, or nervous system.

The ghastly but tranquil features bedewed with tomby mist, the

motionless thorax, the pulseless wrist—all these shape themselves into a picture with which almost every surgeon is familiar. In this case life is extinct, and from death to dust the pathway is straight, and all that lies between the patient and the grave is a death-certificate.

The following I take from our hospital records :

CASE V.—Patient 60 years of age and quite feeble. Heart, lungs and kidneys sound. Small hard tumor in Douglas's cul-de-sac, which causes much suffering. Prognosis very grave. Treatment: rapid abdominal section. The growth, an ovarian carcinoma, lifted and a ligature passed through the broad ligament, when it was announced that both respiration and circulation had stopped. The heart was still, and not the faintest sign of respiratory effort could be detected. The patient was inverted and artificial respiration resorted to, and was accompanied by hypodermic stimulation. For some time all effort seemed in vain, but slowly and faintly the pulse reappeared, and in about ten minutes she began to breathe and life was resumed. Actual time of operation a little over fifteen minutes.

There is no more tragic scene in human life than sudden collapse on the operating-table. To know that one's hand has shortened the life of a patient, even though doomed by some pre-existing disease, is a horribly unwelcome sensation, but to know that resuscitation is possible, even when life seems extinct, robs operative surgery of much of its horror.

While we regret exceedingly that, with our present knowledge, we are unable to give the *rationale* of the phenomena of surgical shock, the great and absorbing question should be its prophylaxis, and I believe there is no other means by which so much can be accomplished in this direction as by rapid operating. Remember, that upon the operating-table it is often impossible to differentiate traumatic shock from the toxic effects of our anæsthetics; that this period is usually characterized by subnormal temperature; that beyond a certain point every inhalation of the anæsthetic increases the depression; that, at best, operative insensibility means the establishment of a tendency toward death, and that the culmination of this tendency may occur during one single minute which is unnecessarily added to the time of operation. This thought should underlie all our surgical procedures, but I am afraid we may justly be charged with more or less disregard of this principle. There is not enough attention devoted to the preoperative arrangements, and, conse-

quently, too much dilly-dallying during the operation. How often have I seen an hour and more consumed in a simple trachelorrhaphy which could easily be accomplished in twenty minutes, or even twelve or fifteen minutes, with competent assistants. This must not be regarded as a reproach to beginners, but to those who have been operating long enough to possess much better technique. I would not be understood as desiring to sacrifice methods (good methods) for rapidity, but that I plead for better methods in order that the operative period may be reduced, and with it the tendency to shock.

The preparation of the patient for a state of invalidism, too, is all important; and this having been done, it should be a part of our professional ritual to operate in the morning whenever possible. I am well aware that there are lesions that can neither wait for preparatory treatment nor the morning hours; but the fact that this is just the class most prone to shock but shows the importance of the above observations, when they can be carried out.

Tranquilizing the patient's mind, the administration of medicine before operation, and the maintenance of proper temperature during the operation, are too familiar to bear comment.

Nineteen years ago it was taught that inflammation and suppuration were reduced to the minimum, and that they were the inevitable accompaniment of operative surgery. Let us hope that our present ideas may be as abruptly changed, and that surgical shock may yet be dispelled from the list of surgical complications. At present, however, it must be admitted that shock cannot be positively averted, and that the best the surgeon can do is to equip himself for the comprehensive grasp of critical emergencies.

Collapse on the table has been sufficiently dwelt upon already. I might add, that in two cases I fancied I obtained relief by Maass's method of rapid and rhythmic compression of cardiac region, but I cannot yet speak with any degree of positiveness of this method. In one case I obtained an abrupt renewal of respiration by anal dilatation. It has failed me in many others. In post-operative shock we can find a place for our homœopathic remedies, and while I never omit the general measures deemed necessary, or at least, essential, I have acquired an immense amount of faith in camphora (low, of course). I would give more for this drug than for all the rest of our materia medica. Arsenic is good, and so is veratrum alb., but often the vitality is so low that the stomach is inactive, and we can obtain no results by this route.

In such cases a favorite resort with me is enemata of warm and

strong black coffee, from a half pint to a quart, and repeated as fast as it is absorbed or until reaction is secured. Dr. Van Lennep has obtained good results from enemata of whiskey and valarianate of ammonia, a teaspoonful of each.

After all, our main reliance is upon cardiac and respiratory stimulants, artificial respiration and artificial heat.

Copious intra-venous or intra-cellular saline injections will always be remembered, especially if there has been much hæmorrhage.

The most manifest indications point, with imperative necessity, to tiding the patient over the perilous but brief period, and our success in obviating the tendency to death will be in proportion to our ability to distinguish the direction from which death is threatening.

STICTA PULMONARIA.

BY M. D. YOUNGMAN, M.D., ATLANTIC CITY, N. J.

THERE is in our "lumber loft" among the neglected remedies, one, sticta pulmonaria. The "polychrests," true to the malign instinct universal among the dominant of this earth—have relegated it to the shades of hazy somnolence, where it exists as a memory only, a possibility, a "Witch of Endor," to be consulted in the hour of our dire need when the polychrests have failed us. For a number of years now I have been going more and more to this "familiar spirit," half unbelievably and falteringly at first, because of the little I have seen published concerning it, and the meagre testimony borne in its favor at medical gatherings. It has become a trustworthy remedy to me, and I turn to it with that warmth of heart and expectancy—almost assurance—one feels toward one's tried friend. And I mean in this brief paper to speak of its virtues, particularly as signally exemplified one year ago, at this season of the year.

March 2, 1892.—Mr. N., of Detroit, Mich., æt. 53, had the grippe in December preceding, which left him with a hard racking cough, some dyspnœa and expectoration of glairy, tough, stringy, mucus, worse during the evening and early part of night; cough gave him great pain all through the chest and particularly under the arm-pits, when he supported the chest with his hands while coughing. Said he felt hot, scraped, and dry under the sternum, expectorated some

blood in the morning; sublingual temperature 101.5 at 11 A.M., had lost twenty pounds in weight, was nervous, anxious about himself, and slept poorly at night; was taking at the time rumex. I gave him 5 drops tr. sticta in \mathfrak{z} ij of water, one teaspoonful every two hours. Cough was better in twenty four hours, second night slept well, and cough entirely disappeared, taking all the other chest symptoms with it in one week from first visit.

March 2d.—Miss A. P., æt. 30, of Pittsburgh, Pa., had had pneumonia she said (probably capillary bronchitis), from which she was very slow in recovering; as soon as she was sufficiently recovered to stand the journey, her physician sent her to Atlantic City. On my first visit, I found her with a hard, spasmodic, racking cough, almost incessant, which came on in paroxysms of coughing and ended in violent coughing, choking and sneezing, during which she quite lost her breath, the tears flowed from her eyes, and after which she had dyspnœa and an asthmatic constriction of the throat. She said prior to leaving home, her physician, who had been extremely attentive to her, had the cough under complete control, and she ascribed its recurrence to our stimulating climate. As arsenic jod. was the remedy she had received at home, that was prescribed, but the effect was nil. The third day, spitting of bright-red blood having set in, millefolium was given, but without benefit, and on the fourth day sticta 1x was prescribed when all the symptoms rapidly disappeared.

March 6th.—Mr. J. McC., æt. 38, of Philadelphia, had the grippe in the early days of February; convalescence retarded, suffered with hard, dry, racking cough, which came in paroxysms, worse from 6 P.M., until nearly morning; sleep much disturbed; this man was of rheumatic diathesis and his cough had a peculiar "throaty" sound which was very distressing to hear. Upon being asked, "what made him cough," he said, "a tickling spot on the left side of his throat," and that he tried in coughing to direct the cough to that side to "scratch" the spot. Sticta ϕ gtt. v. ad. aq. \mathfrak{z} ij, cured him in eight days.

March 9th.—Miss B. M., æt. 12, of Philadelphia, had the whooping-cough in fall preceding, "took cold" afterward and had bronchitis, which left her with a hard, dry, racking cough, dyspnœa after coughing, expectoration of a tough, colorless, glairy mucus; auscultation discovered an emphysematous condition of lungs; cough wheezy and almost incessant. Sticta cured in three weeks.

March 11th.—Mr. H., Pittsburgh, almost a duplicate of first case mentioned. Sticta cured in ten days.

March 15th.—Mrs. W. B. C., Rochester, N. Y., had the grippe in February; found her suffering with dry, racking, incessant cough, expectoration glairy, profuse, and streaked with blood, dry asthmatic wheezing in chest; cough caused headache. Sticta 1x dil., gtt. v. quadrihor, gave great relief, five days it was followed by sulphur 6, which completed the cure.

March 17th.—Miss H. B., æt. 28, Boston, had the grippe, which

left her much prostrated and with a hard, racking cough, paroxysmal, occurring in the morning; raw, scraped feeling under sternum and scapulæ, expectoration scanty, yellow; the evening cough often brought on nose-bleed which relieved the coughing, and the headache which cough produced. *Sticta tinct. gtt. v. ad. aq. ʒij*, relieved all the symptoms and patient was well in two weeks.

March 21st.—Mr. C. B. N., æt. 50, Chicago, had just had an aggravated attack of "influenza." Said he had rose cold every spring, hay-fever all summer, autumnal catarrh all the fall, and a succession of colds during the winter. Was much emaciated, had a harsh, dry, racking cough, little expectoration, was much worried about himself, said "he had everything to live for and nothing to die for." Gave him *sticta tinct. 5 gtt. in water, ʒij*, forced feeding and inhalations of compressed air, and in a month was discharged well of cough, and in better general condition than for some years.

March 25th.—Miss C. A., æt. 19, Chicago, has as sequelæ of grippe, hard racking incessant cough, which produced asthmatic constriction of throat. *Sticta 3x* cured.

March 27th.—Mrs. K., æt. 40, Cleveland, O., had pneumonia in January. Presented herself with dyspnoea, worse upon walking; hard, dry-sounding cough, but considerable yellowish expectoration, no appetite, sleep disturbed, sweat at night; arsenic jod. was prescribed; but on the second visit a collection of fluid was discovered in right pleural cavity, which was aspirated and a pint of straw-colored fluid withdrawn. Contrary to expectation the cough and dyspnoea did not improve and *bry. 3x* was prescribed, but without relief. *Sticta tinct.* was then given, together with careful inhalations of compressed air, which eventually cured.

March 29th.—Mrs. H. H., æt. 42, Albany, N. Y., had an attack of bronchitis in January, which left a harsh racking cough, with pain all through the chest upon coughing, has a spongy condition of the mucous membrane of pharynx, which bleeds easily, has had several attacks of asthma, has hay fever each August, paroxysms of cough often terminate in convulsive sneezing, which she dreads because it is followed by asthmatic symptoms. "She 'takes cold' in her head, which in a day or so goes down in her throat, and thence into her chest." Every "cold" she gets serves her in this way. *Sticta 1x dil.* promptly (five days) relieved her, and she was advised to continue its use together with douching three times a day with *R. soda bicarb. ʒj, aq. therm. oss.*, which resulted in great improvement and she almost entirely escaped the usual visitation of hay fever.

IN CONCLUSION.

1. *Sticta* is indicated in harsh, racking, incessant, "unprofitable" cough, of spasmodic type.

2. It is particularly adapted to neurotic, rheumatic, gouty individuals.

3. It is more valuable in subacute and chronic cases.
 4. It is more suitable to old age.
 5. It allays irritation, soothes irritable tissue, removes hypersensitive conditions of the respiratory mucous membrane, and promotes sleep.
 6. It might prove a remedy for whooping-cough.
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THE PHYSICIAN OR DOCTOR OF MEDICINE, FROM THE INTELLECTUAL,
THE EMOTIONAL, AND THE MORAL STANDPOINT.

BY J. NICHOLAS MITCHELL, M.D., PHILADELPHIA.

(A Valedictory Address delivered before the Class of '93 of the Hahnemann Medical College of Philadelphia, April 19, 1893.)

MERCHANTS and business men generally are in the habit, at fixed times, of taking what they call "an account of stock," in order to determine their business condition and to ascertain whether their past year has been one of profit, and also to satisfy themselves of their ability to enter into new ventures and to discover what things may be needful to add to their stock on hand, in order that they may succeed in the year that is before them.

While professional men are not obliged to do this in a business sense, yet is he most fortunate who can find time to stop now and then, in the midst of the rush of his every-day work, long enough to ask himself the question: "Has this year been one of profit to me?" "Is my stock of knowledge and are my personal characteristics such as to enable me to contend with the difficulties that are before me?" and who can take advantage of such a time of introspection to look ahead so as to become acquainted with the character and kind of work that is before him.

Such a period you have been going through during these past few weeks, and such an opportunity for introspection and self-examination has been offered to you while your teachers have been taking "an account of stock" of you. And now that they have presented you this day to the Board of Trustees as worthy to receive the diploma of Doctor of Medicine, it becomes your duty to think upon the future, and to devote some time to the consideration of the work that is before you; of the responsibilities that you will assume with the diploma that you will receive this evening; and as a means to

aid you I invite you to consider with me, for a few minutes, the character and duties of the physician or Doctor of Medicine from three standpoints, viz., the intellectual, the emotional, and the moral.

During the three years that you have spent at college your minds have been trained constantly, both by clinical and didactic teaching, in order to prepare you for your future work, and I hope that no one who is listening to me errs enough to suppose that with the attainment of the diploma there has come a time for ceasing to study.

It cannot be expected that a college course can do more than show to a student how to educate and make use of his different senses, and to impress upon him the important fact that each of these senses is subject to improvement under training and intelligent use of it.

That the ear, which, when first placed to the chest of a patient, can only hear a confused murmur of sounds that seem to have no reason or explanation, can at length be so trained that it can distinguish, first, the sound belonging to the different organs, and then the finer differentiating sounds of the same organ, and at last becoming familiar with these, is capable of noting the kind, the character, the tone, and the pitch of these different sounds.

And as it is with the ear, so it is with the other organs of special sense. And while it is a fact that he who is gifted by nature with a great amount of sensitive appreciation of any organ can use it at first better than his less gifted fellow-student, yet experience and education prove that, with diligence and continued use, any organ may be trained into intelligent use.

It is important, however, to note and remember how necessary are the habits of accuracy and thoroughness in the training that I have hinted at. To be observant of those things which pass before the observations of the different senses; to have all the different senses thoroughly trained and alert and ready for use; to be drilled in the habits of exactitude and of absolute truthfulness of detail, with habits of *thoroughness* in manner of work, are then of the utmost importance as mental qualifications to the physician.

But the closest observing powers,—exactness, truthfulness, and thoroughness,—important as they doubtless are, are not sufficient unless memory has been trained to such a degree that comparisons may be made between what is heard, seen, or felt to-day, and what was seen, felt, or heard yesterday or many days ago, in order

that results noted as following upon certain conditions may be remembered, and a logical deduction made as to the probable results to be looked for when these conditions, or some similar, are again noted.

In other words, the intellectual requirements of the physician call for the training of and the use of all the senses, and such a training can never end. The habits of study, the ability to imbibe quickly the meaning of that which is read and learned, and the happy faculty of remembering, with the logical acumen of knowing how to apply it, are only learned easily before the days of active professional work, and he who delays to read and study until he gets practice will find that then he has but little time, and that such study is most unsatisfactory and difficult. With the practice comes study of a different kind, a study not from books alone, but of disease from disease, and happy is he who then has his mind stored with the written knowledge, and his senses trained by intelligent practice and use, with logical faculties well cultivated.

And permit me to urge upon you the importance of educating the logical faculties, and of training yourselves to habits of directness of thought and ability to test and decide upon theories.

Nothing is so deleterious, nothing so much destroys a man, as to theorize and turn and twist a thought irresolutely until the practical becomes lost in the maze of theory, for

"The native hue of resolution
Is sicklied o'er with the pale cast of thought,
And enterprises of great pith and moment
With this regard their currents turn awry
And lose the name of action."

Just here I wish to call your attention to the difference between the meaning of the two words, "physician" and "doctor."

The primary meaning of the former is, "one who prescribes medicines for the relief of the sick;" while the primary meaning of the word "doctor" is "teacher." Through custom and usage these two words have come to be used synonymously, but originally they differed both in meaning and use, and the title of doctor was applied to physicians in the same way as it now is to doctors of divinity and doctors of laws, etc.

This definition is well illustrated in the scene in the Merchant of Venice, during the trial of the cause between Shylock and Antonio, where Portia is introduced as a young doctor whose duty it is to

expound the law and to pronounce the judgment. Therefore, noble a life as it is, "to prescribe medicines for the relief of the sick," the doctor has a still higher and nobler duty even than that, since it is his bounden duty and privilege to strive after the means and to instruct others how to avoid sickness and misery.

We must, all of us, admit that a large portion of the misery of man is the result of diseased condition of the body, and, realizing this, also recognize that such misery is not the result of spite and cruelty on the part of nature, but rather is caused by ignorance and folly and sin on the part of man, and that man has done much to make for himself all the miseries that infest the world. Diseases of all kind smite down both young and old, but when once it is learned that they are often caused by myriads of germs that float in the air or the water, and that one has but to observe the simplest rules of sanitary science, to filter and to boil the dangerous water, to insist upon free currents of air, and to breathe through the nostrils as nature intended that we should breathe and not through the throat, and they are robbed of half their deadliness."

Why is small-pox so thoroughly stamped out as an epidemic disease? Why has gaol-fever disappeared? Why is it that cholera is so far under control that even though it is brought to our very shores it gets no foothold in our country; and how is it, that while it occurs in all its intensity in one part of the ship, yet it is kept entirely away from the rest, except that the simplest laws of nature are better understood and taught.

Sir James Paget says: "Past all counting is the sum of happiness enjoyed by the millions who have in the last thirty-three years escaped the pain that was inevitable in surgical operations; pain made more intolerable by apprehension, sometimes prolonged beyond even the most patient endurance, and then renewed in memory and terrible in dreams. . . . How has the use of anæsthetics enlarged the field of useful surgery, making many things easy which were difficult—many safe which were impossible."

And if one considers the manifold blessings that have resulted to humanity by the understanding use of aseptic and antiseptic measures for the prevention of disease, and realizes how all these blessings are due to the teachings of doctors of medicine, it cannot but make one feel that the glory of one who has illuminated the world with some grand truth as to the cause of disease, and as to the method of preventing it, is far greater than is his who has only taught us how to cure existing diseases.

Remember, then, this duty of your profession and prize it highly, feeling, every time that your advice is sought as to hygiene or diet, or in preventive medicine generally, that it should be given only after thoughtful and careful study, with a full realization of the great responsibility that belongs to one whose duty it is to teach his fellow-mortals how to avoid the follies and wrongs that result in so much misery and wretchedness ; for, as Professor Huxley says : “ We live in a world which is full of ignorance and misery, and the plain duty of each and all of us is, to try and make the little corner he can influence somewhat less miserable and somewhat less ignorant than it was when he entered it.”

In the efforts that are made in life which result in the most marked effects, it will frequently be noticed that the greatest attention has been paid to detail.

The great commanders of armies have been noted for the care with which they have looked after even the smallest minutiae before they have entered upon some campaign that, in its results, has electrified the world ; lawyers of great eminence have told us how they have won a cause upon some little point, some little flaw, apparently so insignificant that it had been overlooked by their opponents, and yet upon it depended the whole question at issue. And so, also, is it in the practice of medicine ; where one has to do with great things once, he has to meet with small things ten times. I heard a physician criticize another once severely in saying : “ I never worry when I succeed him in the treatment of a case which he has failed to cure, for I expect to find that he has introduced into the treatment of the case all the newest fads but has overlooked the simplest every-day methods.”

Above all things, the physician must be observant of everything that belongs to any case under his care, with every sense alert to discover every symptom in his patient, both small and great ; and upon the homœopathic physician there falls a great responsibility in this particular, that he may advance the *materia medica* ; for, upon the application of it hinges the great difference between him and other practitioners ; for, while the study of pathology, of diagnosis of disease, of surgery, and of all the other cognate branches belonging to his profession, are and have to be studied in order to apply the *materia medica* properly, yet it is by pointing proudly to the therapeutics of his school, that he answers the oftentimes asked question as to what discoveries in science are owing to the homœopathic school, for, as Broussais says, “ the real physician is the one who

cures; the observation which does not teach the art of healing is not that of the physician; it is that of the naturalist."

And now, as a final thought on the intellectual life of the physician and doctor of medicine, I would urge upon every man that, while the reading and study of works devoted to medicine should be his first and most important duty, that he neglect not other kinds of readings and studies, both in science and general literature. It is impossible for the busy practitioner to keep thoroughly abreast with all the advances that are being made in science, but he should strive to do the best that he can to do so without prejudice to his professional work. And, as such studies are easier to accomplish during the earlier days of a physician's life, as also are his readings in general literature, and because such studies performed at this time will educate the brain to an easier method of accumulating the advanced knowledge which later years brings forth so abundantly, I would urge upon young men to devote a certain amount of time to such studies while they yet have the time; and also, as in these days it is so important to be able to keep one's self quickly aware of all the discoveries throughout the entire world, I consider it as very important for those who can find time in their young days to study French and German, for, later in life when the necessity for such knowledge becomes more evident, then it is harder to accomplish, and time is harder yet to find in which to accomplish it.

But peering into microscopes or listening to diseased hearts with trained ears does not alone constitute the physician. The development of all the intellectual faculties, great and necessary as it may be, will not alone constitute that which is necessary to the physician, for great as is his need for a broad, intellectual culture, for a wide familiarity with knowledge that can be called from books and from personal investigation and study; familiar as he may be with the symptoms and treatment of different diseases; broad and general as may be his education, yet all this is not enough unless he combines with it a sympathetic ability to place himself in unison of feeling with the individual personality of his patient. Like the passenger on board one of the large transatlantic steamers, who, from the start of his voyage to its end, is aware and yet hardly conscious of the steady and regular pulsations of the ship's engines; who, while he passes away the day at his different occupations, feels it unconsciously; who, while at his meals yet has it with him, and when he lies down to sleep is conscious of its steady pulsations beneath his pillow as long as consciousness lasts, and who wakes to find it still

beating regularly and steadily, until at last it becomes so much a part of his life that he is hardly conscious that it continues, but who, when anything occurs that causes it to stop or become irregular in its action, starts to an immediate consciousness of the change, waking even from his sleep in alarm, so also must the physician be so in unison with the diastole and systole of the great heart of the world that, intuitively, he is conscious when any change occurs in its great throbbing pulsations.

His sympathies are called upon from the beginning of feeble life, as he aids, assists, and comforts through the pangs, and sorrows, and dangers of birth, and when life's work is done, and as life slowly ebbs away by the bedside of the dying man he stands, comforting and easing his passage through the dark river, while by his personality and attention he aids also to comfort and sustain those aching hearts who, standing on the shore, see their dear one go out into its depth alone. Can such a life be lived without a great strain on the emotions? Who is called to minister to some poor fellow-mortal whose whole being has been racked and fired by the diseases of sin, and who, conscious that he is an exile from the world, yet comes to his physician with a mute longing, as much for the sympathy of a fellow-man as for the medicines that he needs; who is called upon to hold up and assist in living some poor, broken-hearted creature whose heart has been crushed by treachery and whose life has been ruined by deceit, and who comes as much for the sympathy that will reinstate her in her own self-respect and help her to live her life as for the medicine that she asks for; who is called to visit the fatherless and the widows in their affliction; who sees quivering, weak, sinful human nature in all its reality, when all cloak of hypocrisy or of pride is thrown away, and whose duty it often is not only to prescribe the needed medicine, but also to encourage and teach how to take up afresh the burden of life, how to go on and sin no more; to whom there comes, in all its depth of sadness, one who cries, "Canst thou not minister to a mind diseased?" Who is called upon in times of severe epidemics, when others flee to places of safety, to stand and fight the dreaded foe, without thought of the danger to himself further than to take such precautions as science teaches him to be necessary; who, when weary and fatigued both in body and mind, must cheerfully respond to the calls of his patients, not only to prescribe the medicines that may be needed, but also to give the cheerful and ready sympathy that may be required.

Does any one who listens to me think that I exaggerate the pict-

ure that I try to portray? Or that I seek to make the character of the work of the physician seem needlessly pathetic? For if there be such an one, I think that he has not grasped the full meaning of the duties of a physician nor the great privileges of his life, for, as the author of *Romola* says: "We can, indeed, only have the highest happiness, such as goes along with being a great man, by having wide thoughts and much feeling for the rest of the world as well as for ourselves." Nor would I wish to seem to teach a sentimentalism, either for its own sake or for professional advantage, for, as Prof. Henry Reed long ago said on this subject: "Such, it must be borne in mind, can have no practical influence on character if it accomplishes nothing more than the production of emotion instead of being carried into action; for it is a great law of our moral beings, that feelings, no matter how amiable and virtuous, will surely perish if they be not converted into active principles; nay, they may coexist with conduct the most selfish and unfeeling; there may be a worthless sentimentalism utterly delusive and negative, and this, by due transition, may pass into odious self-indulgence or still more odious inhumanity."

"In the worst days of the French Revolution the very men who, in the theatres, applauded the heroic sentiments of Corneille and were melted even to tears by the pathos of Racine, rose upon the morrow's morn to join in the ferocious cries for blood that echoed in the streets of Paris. And further, if this example shows how worthless and wicked mere sentimentalism may be, self-indulgent in the luxury of ideal woe, it also shows that the sight of actual suffering may obliterate all sympathy and harden the heart by familiarity with human distress or agony looked upon as a spectacle."

Nor would I wish to make it appear that the work of the physician is only such as calls upon his emotions of pity, of sympathy in suffering and distress, or for acts of unselfishness, for there is much in his life also that calls for gratitude, for thankfulness, and for love. My desire is simply to call attention to the fact that he must often have emotions of a very varied kind called upon, and that therefore it becomes him to study them that he may educate those that are healthy and suppress those that are unhealthy; for most assuredly it is part of the physician's mission to exercise mercy and sympathy and love for his fellow-man and often by actions, rather than by words, to seek to comfort and sustain the sufferer; by cheerfulness and hopefulness of manner to encourage, and by the magnetism of such mercy, sympathy, and cheerful hopefulness, to help those who

are sick to fight their battle for life, and those whose life has been racked and ruined by sin to determine to manfully throw off the shackles that bind them in a degraded slavery. There is a bathos as well as there is a pathos. So also there is a proper use and education of the emotions and an improper one, and I think it not unimportant to remember that it is possible to train the emotions that are healthy as well as it is possible to train the senses.

Upon one occasion I overheard a physician, who had been attending a patient who was in great agony, say, when he had lost his self-control and knew no longer what to do for her: "My dear Madam, I feel so sorry for you; I sympathize with you from the bottom of my heart." And to this her quick reply came: "I do not want your sorrow; I do not want your sympathy; I want your aid." And as I listened there came to my mind the old Latin motto, *face aut tace*—do or be silent.

A patient told me once, when speaking of a very painful surgical operation that she had to undergo, that the firmness, resolution, and known reputation of the surgeon who was to perform the operation had encouraged her much, but even more than that, however, she said, "is the fact that I feel at each visit that he has made to me that he is sorry that I must have the operation performed."

On another occasion a lady told me since the death of our dear friend Dr. Trites, that once, when in great suffering, she looked up at his big, noble, manly figure, which from its strength was in itself a comfort; but more than that, she said "I saw a tear glisten in his eye as he quietly and silently went about his work to give relief to me." Not a word was spoken, not a precious minute wasted, and yet the poor sufferer felt the tenderness of her big physician and was comforted.

The physician can educate himself to have patience and long suffering. He can always be a gentle man, and need not fear to show tenderness when he can also show strength. He who can only show tenderness and has no strength behind it, shows also his weakness, and errs.

And now, gentlemen, I will occupy but little of your time in speaking of the moral side of the life of the physician, for much as might be said on such a theme we have to do directly only with his life as a physician or doctor of medicine, for in all other respects he is governed and should be influenced by the same general laws that apply to other men. But I would again remind you of the defini-

tions that I have already given to you of the two words, *physician* and *doctor of medicine*, since they define to you what are the duties to which you consecrate your lives. So that if ever temptations, most eloquently and most pathetically and even most alluringly presented, offer themselves to you to do something through your skill and knowledge, gained by your studies, that does not come under the definitions of "prescribing remedies for the relief of those that are sick," or under that other definition of "teachers" of giving advice how to relieve existing disease or how to live that disease may be prevented, then I say remember that if you yield to such temptation the authority of the diploma that is given to you to-day is exceeded, for all the rights and privileges that go with it are embraced in these definitions.

Remember that you owe to your patient the best that is in you, both in the way of striving to cure disease and the prevention of it, and that you can never excuse yourselves for neglect or for ignorance, and that therefore in any case in which you feel yourselves baffled, that you owe it to those who are trusting you to ask for aid and consultation with some other practitioner older or more experienced in such a case. Never hesitate to accept of counsel or to listen to advice, for even though the counsel or advice may not have any intrinsic value, it enables you to see how the subject may be viewed by another; for we are all of us only too prone to become like the horses that we drive with blinders, and who can look in but one direction.

In Darwin's *Autobiography* we read: "I had, also, during many years followed a golden rule, namely, that whenever a published fact, a new observation or a thought came across me which was opposed to my general results, to make a memorandum of it without fail, for I had found, by experience, that such thoughts were more apt to escape from the memory than favorable ones." And another writer says: "Experience teaches that we can learn most from those authors with whom we do not agree."

And finally, see to it that your relations with your fellow-practitioners shall be guided by rules of fairness and honesty. It goes without saying, that you cannot agree in all things with every one that you meet, and that you will often meet with those who do not agree with you or your opinions; but, let your differences be openly and honestly expressed, if need be, or, if an open expression of difference is not necessary, then a silence in the absence of him with whom you differ, as well as in his presence.

In all things be guided by charity towards the errors or failings of your professional brother ; never acting, or even thinking that your knowledge is so great that you can afford to despise what you may think is his ignorance ; and never erring so greatly as to think, because his opinions on some subjects are not in harmony with yours that, therefore, there can be no points upon which you may agree ; for such judgment is as foolish as though one were to strike two discordant notes upon a piano and then determine that the instrument was tuneless and valueless, overlooking the many and varied hidden harmonies that could be discovered elsewhere. True charity, remember, does not consist alone in the giving of alms ; a word spoken in defence of the absent, a lenient judgment of intention of wrong, a searching always for what is the best in those with whom we come in contact, or, to quote the words of another, " In all things charity ; in all things see the best in thy neighbor and try to imitate it ; in all things see what is true and beautiful in others, however firm in thine own faith and in thine own opinions."

In the unity, then, of these intellectual, emotional, and moral qualities, we find portrayed the characteristics of the physician, and the outline of the duties that are expected from him ; and while it may be hard to live such a life in all its fulness, yet it is a most worthy goal to strive after, for in the combination of a life spent in prescribing remedies for the relief of those that are sick, in studying after methods whereby to ameliorate the sufferings and sorrows of humanity, in teaching fellow-men how to live, in the constant exercise of such healthy emotions as pity, sympathy, and love, and in the intellectual life with all its joys, for the most permanent joys and happiness come to us through the intellect, as a truth once acquired is always abiding, and a life spent in searching after truth is one of peace, and a friendship made with books is a lasting friendship,

" For books, we know,
Are a substantial world, both pure and good ;
Round these, with tendrils strong as flesh and blood
Our pastime and our happiness will grow."

Such a combination, I say, makes the life of the physician, when properly lived, an ennobling one, notwithstanding all its cares, its anxieties, and its drudgeries, and one that any man may well desire to live, as of him it may truly be said, "*pertransivit benefaciendo*" (he goes about doing good). And therefore, gentlemen, I congratulate you on your choice of a profession, and for the success that has crowned your efforts to enter it, and, representing your former teachers, I bid you welcome.

ACUTE MELANCHOLIA.

BY CHARLES B. GILBERT, M.D., WASHINGTON, D. C.

LACHESIS.—Mrs. S., aged 58, had been worrying for six months over loss of income and position in society, until acute melancholia set in, with great and rapid, quick loquacity in the morning and when people were with her; talked about the misfortune she had brought on the family; about the salvation of the good, the damnation of the wicked; that others must die, and how sorry she was, etc.; could get hardly anything out of her as to her condition, often nothing, only that she had pressure on top of her head; her tongue was white, and she apparently had no sleep; did not want to be questioned or looked at; would turn away or cover her face with a handkerchief; hands always very busy when talking; nervously working or twisting something; wanted to scream; she was somewhat better in the evening; restless, couldn't sit still. Lach. cc. twice a day for three days produced an aggravation, after which it was suspended; in twenty-four hours there followed great improvement, which was shown by her becoming rational and being able to tell the history of her case, although in a nervous way, and how she felt at that present time; for weeks she had a band about her head, and became very nervous whenever she undertook anything, even what she was accustomed to; then something shot down into her head from the vertex and from her heart down through the body, which made her double down and left her weak; following that came the intense nervous state in which I found her. The day she was rational she complained much of a drawing distress about the heart and around to the back, which kept her constantly twisting and squirming. No medicine was given; her bowels had not moved for several days, and the next night, about 4 A.M., she complained that she wanted to have a stool, but could not; she was relieved by enema. The next day she was nearly as bad as ever, and was given lach., one dose. Better toward evening again; the next day much better, and for the first time she ate her breakfast. The distress about the region of heart was less, but she was constantly swallowing, felt choked, and could bear nothing about her throat. She said, "I can't control my throat." The home physician, a recent graduate, said: "If I didn't know that you were giving a high potency of lach., I would say that she was suffering from an aggravation."

It is a pity that the drawing of scientific conclusions, *according to prejudice*, was not confined to recent graduates! Inasmuch as the diseased condition was working from an interior situation to a more exterior situation, and as the mental state was better, no medicine was given; the bowels had moved freely; tongue white; pulse 84; she continued to improve without medicine for seven days, when the lach. was repeated. The bowels were so costive, that nux 30x was given May 8th, and on account of the great nervous apprehension, two doses of aes. 30, one each day, on the 9th and 10th, followed by nux 30x. She received lach. May 11th and 12th, lyc. 30x on 13th, and lach. from May 14th to 20th inclusive, varying from cc. to 46m. (Fincke); on May 21st, 23d, 24th and 29th to June 3d inclusive she had one dose of sepia cc. each day for constipation and sallow skin, although Hering says that it is not compatible. She left the hospital apparently cured, and has since regained her weight and usual state of health.

May 5, 1893. The daughter of the patient tells me that her mother is in her usual good health, although she has passed through the ordeal of the loss of her husband.

A COMPARATIVE STUDY OF ACONITE AND BELLADONNA.

BY T. HART SMITH, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

ACONITE.

Delirium. Worse at night, has the character of ecstasy.

Inconsolable anxiety, restlessness, nervousness and tossing about.

Prediction of time of death.

Giddiness when rising to sit up with vanishing of vision.

BELLADONNA.

Delirium of a violent nature, with great loquacity, with visions as soon as the eyes are closed, accompanied by violence, beating, tearing of objects and spitting.

Unconsciousness. The patient cannot hear or see any one, or else violence.

Great cunning, violent talking or forgetfulness.

Giddiness, as if on a swing; or vertigo, with unconscious falling down.

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| Heat in the head with perspiration of head. Pale face. | Heat in the head, with congestion of blood to the head. Pulsation of the arteries. |
| Fullness and heaviness of the forehead. | More stupefying headache in the forehead, with congestion of blood to the head. |
| More pain on the left side. | On the right. |
| Headache better when quiet, worse when raising the head. | Worse when laying down, better when sitting up. |
| Red face. | More purple, more burning, bloated and puffy. |
| Dry peeling off of the lips. | Lips cracked and bleeding, hard swelling of the upper lip. |
| Tingling in the throat, hands and feet. | Sensation of constriction in throat with desire to swallow. |
| Tongue is white-coated. | Coated with a thick layer of mucus or red. |
| Bitter taste of all food and drink, except water. | Sour taste of bread. |
| Vomiting of bloody mucus. | Vomiting of pure mucus or of acid. |
| Vomiting of what has been drank. | Vomiting of bile. |
| Evacuations white. | Green stool. |
| Small stools with straining. | Involuntary evacuations. |
| Short breathing. | Short breathing. |
| Frequent short breathing when rising from a recumbent position and while sleeping. | Short breathing generally accompanied by great labor of the chest. |
| Dry short cough. | Nightly dry barking cough. |
| Stitches in the chest aggravated by breathing. | Congestion of the chest. |
| Palpitation of the heart with anxiety. | Violent palpitation reverberating in the head. |
| Tingling in the fingers. | Twitching in the hands. |
| Loss of power of hip and knee-joints. | Stitches in hip-joint. |
| Sleeplessness with anxiety, continual tossing about. | Deep stupor-like sleep. |
| Sleeplessness and delirium with closed eyes. | Sleeplessness caused by visions when closing the eyes. |
| Great restlessness and anxiety. | Boisterous temperament, full of rage. |

NOTES ON SOME CASES OF HIP-JOINT DISEASE.

BY L. W. THOMPSON, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

IN a subject so well known as this, it will not be advisable to take time to lay down the whole course of the disease, therefore I shall endeavor to give only a few points, as they are connected with cases that have actually been under my personal supervision, and the first point is in regard to the value of early rest. This is so clearly indicated and yet so often neglected, I want to make it a trifle more prominent. As one cause for neglecting such a course is the unwillingness of parents to consider their children sick. They will banter around the subject and in spite of your most earnest advice, will still allow the child to use the joint more or less of the time. Just in the beginning of the process where the joint surfaces are practically in only a hyperæmic condition, as yet no adventitious deposits and no fungous growths, the removal of mechanical irritation caused by motion becomes the foremost plan toward absolute prevention of serious consequences.

The means of accomplishing this will vary as you all know from simple rest in bed, on to continuous traction by weights, the high sole and crutches, and fixation splints. The second point is the value of early building up of the entire system. Just one moment of retrospect—our thoughts in studying homœopathic materia medica are early directed to cures made by Hahnemann of what he called the “itch” by means of homœopathic remedies. Now though the question may remain open as to whether the cases so cured were done by killing this particular parasite and considering in addition the testimony of long lines of cases of various parasitic diseases whose symptoms have been removed by internal treatment alone, seems to bring more clearly to view the importance of instituting measures to build up in the system a new strength which shall enable it to resist the founding of colonies of destructive agents in these joints that have this beginning inflammation in them.

The means I refer to are, on the one hand, careful selection of your remedies for the case, and secondly a most thorough process of nutritious feeding even though the child may seem healthy. What is needed is rather placing the child in a higher state of healthful-

ness than may at first glance seem to be his normal condition. This being done there is just so much more power of resisting the inroads of new disease factors (animal or not).

My third note is to call attention to the insidiousness and persistency of one special class of cases, viz.: the dry cases if you will so allow me to call them. Here we will have present most of the symptoms of the disease—but in the two or three cases I have seen in as many years the symptoms have always been rather modified. No intense pain. No great involvement of the general system—the local signs all modified—and when we do see them in an aggravated state they soon yield and are discharged cured—but will shortly have an aggravation of symptoms again.

I have on hand now one case that has twice been discharged without a sign of any further trouble, but now comes back with symptoms sufficiently marked to render an early operative interference advisable with the probability of finding a considerable necrosis present.

I recall seeing one case at least operated where it was very difficult to determine what was the matter with the case—the signs were so mingled; at no time was there the suspicion of even an effusion into the joint. Yet on making an opening into the capsule the entire head was found necrotic and removed simply by picking it out of the cavity.

The fourth point is that while abscesses in the region of the hip-joint are always suspicious of its involvement they do not necessarily so arise—and here I shall simply quote two illustrative cases.

CASE I.—Walter R., was run over by a large wagon drawn by six or eight horses in a circus parade. The policeman who picked him up said he actually saw the heavy wheel go over his body. There were marks on the anterior surface of the right thigh below Poupart's ligament, on the symphysis pubis above the penis and on the left iliac region above the right leg. There were broad abrasions, the skin taken off as large as my palm.

No sign of fracture. He was treated by absolute rest, and various hot lotions. He recovered fully and walked and played with perfect freedom. Was then sent home from the Children's Hospital, where he had been treated, apparently quite well. In three weeks he was returned with an acute abscess in the right inguinal region which had come on during a few days. This was a part not involved in the surface injury and a deep lesion was immediately expected, but upon evacuation none was found, neither any sinus lead-

ing toward bone, nor any tenderness nor other symptom of a suspicious character, except the late occurrence of an abscess where there ought to have been serious crushing of bone. In this case granulation proceeded rapidly and within a few days (at least two months) after the abscess he remained perfectly well.

CASE II.—Ralph A., æt. 4 years, says he fell against a chair some time back. He favors the limb. It seems longer than its fellow—the gluteal crease is obliterated. There is arching of the spine on depressing the popliteal space of the right side. Pain on any motion. Pain at the knee—in fact almost a perfect picture of hip-joint involvement. However, just above the great trochanter on outer side of thigh a swelling develops and deep fluctuation is made out. It is incised and drained thoroughly. Here, too, diligent search is made toward the joint with the expectation of actually finding an opening but none such exists. Granulation quickly fills the entire cavity and now (a month later) the boy can walk perfectly and every vestige of hip-joint disease is gone.

CASE III.—An abscess at the hip-joint may closely resemble that from diseased vertebræ. This, too, I shall simply confirm by an illustration. The patient, a little colored boy, underwent rapid emaciation and loss of vitality; the whole course of his disease was noted for its quickness. He was brought to a friend of mine in a rather advanced stage, presenting a spinal tenderness, eased by recumbency and gentle traction, stiffness of the left thigh to motion and the presentation of a fluctuating mass under Poupart's ligament. This was opened with great care as to asepsis and found to extend upward into the posterior abdominal cavity beyond the possible reach of the finger. No connection was found with the hip-joint. Thorough drainage and care were used, but the little fellow rapidly succumbed to a general tubercularization.

Post-mortem examination of this abdominal sinus showed that there was no connection with any part of the spinal column but the hip-joint was completely disorganized. The abscess arising therefrom had taken a contrary direction to that ordinarily assumed—and instead of pointing down upon the thigh had actually burrowed up along the psoas muscles and pointed into the abdominal cavity, a course which to say the least was unique and to me was quite instructive.

PODOPHYLLUM is to be used for profuse gushing diarrhœa, coming on in the morning, or more during the day than at night. The stools may contain undigested food and often, in children, deposit a mealy sediment.

THE CAUSES OF UTERINE HÆMORRHAGE (NON-PUERPERAL).**BY E. M. HOWARD, M.D., CAMDEN, N. J.***(Read before the Homœopathic Medical Society of the County of Philadelphia.)*

UTERINE hæmorrhage is naturally divided into two varieties, which, theoretically, are easily separated, but, clinically, are so closely allied that the one is frequently but the earlier symptom and the other a late development of the same pathological condition.

The first, menorrhagia, is a uterine hæmorrhage occurring at the menstrual period. The second, metrorrhagia, is a uterine hæmorrhage occurring independent of the menstrual function. Hence, any complete review of the causation of uterine hæmorrhage involves all of those ætiological questions bearing not alone upon pathological conditions of the uterus and adnexia, but also those complex phenomena leading to conditions that in any way influence the menstrual function.

Taking this view of the matter, it may be stated that almost any disturbance of the general health of a woman may be a causative factor leading to uterine hæmorrhage, viz., menorrhagic; that is, to a too profuse or too frequent menstrual flow.

Such hæmorrhage, therefore, may be only a symptom occurring in the course of a great variety of diseased conditions: In plethoric conditions or in its opposite; anæmic states, as in chlorosis; debility from excessive lactation, or from scorbutic or from any other causes; during typhoid and other fevers, including the exanthems; as a result of cardiac, pulmonary, hepatic, cerebral, splenic, and renal troubles; from ovarian influences and sexual excesses. Even psychological influences are also potent factors.

All these and many other non-uterine disturbances may be the remote causes of a uterine hæmorrhage of greater or less degree.

It is not possible to speak of these conditions in detail, but all of them may be easily understood when considered in the light of the physiological function of menstruation. We have here the periodical occurrence of an increased vascularity and congestion of the endometrium, and going along with it a fatty degeneration of the superficial layers of its cellular structure, which necessarily results in capillary oozing and a bloody flux.

It is easy to understand, therefore, that any serious disturbance

of the general health, and especially such as may favor either the increase of this fatty degeneration or produce grave disturbances of the circulatory system, may and must tend to increase this physiological function to a degree that may menace the health and strength, if not the life, of the sufferer.

It is, however, in the uterus itself that we find the more common causes of the most dangerous forms of uterine hæmorrhage.

These conditions may readily be divided into three varieties :

1. Severe uterine dislocations.
2. Endometritis.
3. Abnormal growths or neoplasmæ of the uterine structures.

These are important as causative influences in the order named, but are clinically closely intertwined, one condition rarely existing without the development, sooner or later, of one of the other forms, and all are explainable, in my humble opinion, upon purely mechanical principles.

The uterus will not tolerate foreign bodies, and this, together with the element of mechanical pressure, will serve to explain most of this class of hæmorrhages. This can easily be understood by a closer study of corporeal endometritis. In this condition, from whatever cause, the uterine walls are thickened and congested, and there is increased vascularity and general congestions of the mucous lining, developed to excess in spots or patches about the mouths of glands. These thickened, red patches are proliferations of the mucous tissue, which may become fungous or polypoid in character, and always play the part of foreign bodies. As a result of their presence the os is usually dilated and the cavity of the uterus is enlarged. In other words, we have a condition simulating that produced by a foreign body in the uterine cavity, with its inevitable consequences. Hence we have, as a result, menorrhagia at first, but ultimately, as fungous or polypoid elements increase, all the conditions of a metrorrhagia.

The condition does not seem to be very different from that existing when portions of the placenta are retained following labor. As is well known, but a small piece so retained will prevent the contraction of the body of the uterus and the closure of the os uteri, which are the safeguards against post-partum hæmorrhage.

When we come to the subject of uterine fibroids and malignant growths, practically the same conditions obtain. These growths produce hæmorrhage sometimes by their pressure and obstruction of the veins, causing endometritis; sometimes by reason of their ulcer-

ation through vascular structures, a purely mechanical condition, but more often by reason of there being foreign bodies encroaching upon the uterine cavity. This is so true clinically that uterine fibroids are found to produce hæmorrhages just in proportion to their nearness to the mucous lining of the uterus,—submucous giving most trouble from this cause, interstitial less, and subperitoneal sometimes none at all.

I think, perhaps, we might sum up the causes of uterine hæmorrhage by saying that menorrhagia is produced by a great variety of influences, both local and remote, which may tax the diagnostician most severely to discover, but which, in general, may only be considered as merely aggravations of normal physiological processes, but that metrorrhagia, the more dangerous symptom, may almost certainly be set down to some definite mechanical cause whose existence it should not be hard to discover.

I have no doubt but that the lines of treatment, to be laid down by those who follow me, will be found to be indicated by similar considerations.

PATHOLOGY OF ALBUMINURIA OF PREGNANCY.

BY E. W. MERCER, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

THE subject under consideration, the albuminuria of pregnancy, would imply the existence of a form of albuminuria caused by or directly dependent upon pregnancy. Whatever our conclusions may be, we should always remember that there is nothing in gestation which exempts pregnant woman from diseases which are usually accompanied by albumin in the urine. Indeed, there is every reason to expect these to be more frequent, when we consider that her exaggerated physiological condition, if we can speak of it in that way, brings her more closely to a pathological state. While many of these sources of albumin are, in themselves, comparatively unimportant, they have great diagnostic value in leading us to or from the graver lesions.

Aside from the functional disorders causing albumin to be excreted, *i.e.*, those cases in which albumin is the only pathological product in the urine, and where no pathological condition is demonstrable, we may have, as extra-renal causes, diseases of the urethra,

bladder, ureters and pelvis of the kidney. These are recognizable by the products of inflammation, pus-cells, and the epithelium characteristic of the part of the urinary tract in which such process occurs. But the most important lesions complicating pregnancy are in the kidney; regarding these there exists a great diversity of opinion. The one, perhaps, more clearly expressing a condition peculiar to pregnancy, is that of Leyden, in his description of the kidney of pregnancy. He considers the condition to be neither one of acute inflammation nor of chronic congestion, but rather of arterial anæmia, and that the changes in the kidney are those of degeneration. But he also recognizes the fact that some cases of puerperal kidney diseases pass on to the chronic form, and resemble ordinary cases of Bright's disease. The disease is regularly developed in the second half of pregnancy, and most frequently in primiparæ. The kidney is relatively large, and of a pale anæmic hue.

On microscopical examination, the epithelium gives evidence of pronounced fatty degeneration. The urine contains hyaline and granular casts, and renal epithelium. All evidences of inflammation are absent. Schroeder recognized this form of kidney lesion, but also an acute nephritis having the usual urinary condition—scanty, profusely albuminous and containing a large quantity of red blood cells, but not a form caused by venous obstruction from pressure of the uterus. As opposed to the last opinion, Rosenstein, in the first two editions of his work on diseases of the kidneys, holds that in these cases there is no active nephritis at all, but only a chronic congestion due to pressure of the pregnant uterus on the veins.

Delafield says, the most important variety of nephritis in pregnancy is the acute diffusive. He applies this to an acute inflammation of the kidney characterized by congestion, and the exudation of plasma, and migration of white blood cells with swelling or necrosis of the renal epithelium, growth of connective tissue in the stroma, and growth of the capsule of the malpighian bodies.

Frerichs considers puerperal albuminuria to be due to an acute nephritis, and that the obstacles to the circulation of the blood in the abdomen, with changes in composition—diminution of red cells and an increase in white and of fibrine—as the causes of such a nephritis. He recognized the fact that, although the disease is usually temporary, it may become chronic.

This is but a sample of the way authorities differ as to the lesions found during pregnancy evidenced by the excretion of albumin, and from this fact I think we may very strongly doubt the existence of

a specific form of kidney disease, but agree with Cassin, when he concludes, in regard to the different theories, in the following way: "Pregnancy produces a condition favorable to the passage of albumin into the urine, but the change of the blood by pressure, or by its constitution, or the influence of renal steatosis, do not explain it, because leucomuria should be as frequent as the gravid state. They explain only the tendency to albuminuria. The fire is ready, a spark is wanted to light it up; then, under the least pathological influence, the renal trouble shows itself without always being the expression of the same lesion."

THE CLINICAL VALUE OF CERTAIN REMEDIES IN THE TREATMENT OF THE COMMONER VARIETIES OF CUTANEOUS DISEASES.

BY LEON THOMAS ASHCRAFT, M.D., M.A., PHILADELPHIA.

(Read before the Harper Memorial Homœopathic Hospital Medical Society, March 13, 1893.)

EVEN under the most favorable conditions, the treatment of cutaneous diseases is difficult, because of their chronicity, their complications, and their frequent failure to disappear under apparently well-indicated therapeutic measures.

When a disease is purely and solely parasitical it is useless to prescribe internally, and when of nervous origin, it is likewise unscientific to administer local remedies, save for temporary relief. Scabies can never be cured by internal medication, nor hyperæsthesia markedly ameliorated with local applications.

Therefore, upon a basis purely clinical, I present a few remedies that have been used, both internally and externally, with decided success, in the treatment of certain cutaneous diseases.

Acne.—While acne is a local disease of the sebaceous glands, yet it must not be forgotten to attribute many cases to a reflex affection. Excluding those physiological changes coincident to puberty, I have been able to refer many varieties of this disease to gastric or uterine disorders, and have treated them accordingly.

In the acne occurring about the menstrual epoch, I have obtained good results from *cimicifuga* θ , three drops every three hours, combined with intra-vaginal douches of very warm water. I may also mention *pulsatilla* θ as of decided advantage in this variety of cases.

In acne of young men at puberty, phosphoric acid, 2x, 5 drops in

water three times a day, combined with the passage of cold sounds, has been superior to other remedies, although sulphur is best suited to the pustular variety.

When the lesions are of gastric origin, proper diet, with the exhibition of *nux vomica*, used alone or in combination with pepsin, is the best remedy. The potency used must suit the individual.

Permanganate of potash tablets, singly, or with boracic acid, are of decided advantage. The method of administration is two tablets, strength, $\frac{1}{10}$ of a grain dissolved in a glass of water.

This solution is to be taken on rising. Its antiseptic properties subdue the formation of putrefactive gases and the morning nausea coincident to acne. Locally, treatment consists in subduing inflammation and removing the charged products of the sebaceous ducts. For this purpose I employ a dermal case, made at my suggestion by Yarnall & Co., consisting of a spear-shaped lance, a curette, dermal forceps, a magnifying glass and a comedo expresser.

While the technique is simple, in order to prevent cicatrization, one must be guarded in protecting the epithelium and corium; hence the triangular spear and comedo expresser is preferable to other instruments. Parenthetically, acne rarely occurs as a distinct affection, being usually associated with comedo and *seborrhœa oleosa faciei*. Treatment is practically identical.

After emptying the ducts, the free use of hot water and a liberal application of a powder of equal parts of bismuthi sub-nitrate and starch, with proper hygiene, will effect a cure within a comparatively short time.

In *acne chronica* and *acne atrophica*, where it is necessary to stimulate the sebaceous glands, the formula of Hebra, the *tincturæ sapis viridis*, four ounces to the pint of water, is superior to other lotions.

Finally, hot water, internally and externally, is most effectual in subduing inflammation and to promote diuresis and hyperfunctional activity of the ducts.

Dermatitis.—Some time ago, at the suggestion of Dr. C. Raue, I was induced to try *hamamelis* θ in the treatment of dermatitis resulting from natural heat. I have used it both locally and internally in a number of cases, and know of no remedy better adapted to such conditions. I can supplement the suggestion by advising its employment in *erythema simplex*, and in mild attacks of chronic *erysipelas*. In dermatitis resulting from contact with poison ivy, *croton tiglium*, 6x, is our best antidote. Locally, a weak solution of hyposulphite of soda will allay itching and inflammation.

Scabies.—Of the many diseases to which the skin is subjected, those which occasion the most acute suffering and discomfort are due to the ravages of the animal parasites. Of this group, scabies and the varieties of pediculosis most frequently demand our attention. Since scabies is caused by the presence of the itch-mite (*acarus scabiei*) treatment is parasitidal. To accomplish its destruction, a hot salt-water bath, followed with a thorough inunction of b. naphthol, grains xxx to vaseline ℥j, is preferable to other methods.

Since it is claimed that the *acarus* crawls only during the night, it is advisable to institute treatment at that time. Internal medication is of little value. Cinnabaris 6x occasionally assists in curing dermatitis. Faithful adherence to these suggestions will remove unpleasant symptoms within a fortnight.

Pediculosis Pubes.—The classical blue ointment is not nearly so effectual in destroying the crab-louse as the local use of *coccus indica* θ , while any unpleasant odor may be suppressed by observing personal cleanliness and using a 1-4000 solution of corrosive sublimate.

Pediculosis Capitis.—The treatment of pediculosis capitis depends upon the ability to destroy the parasites and their ova, which is tedious. A very strong application of tobacco water, or a mild solution of carbolic acid, is usually sufficient, while *viola tricolor* 6x, and *belladonna* 6x, will suppress the glandular enlargements resulting from irritation. It is claimed that *ichthyol* is an excellent parasiticide.

Eczema.—It is a trite saying that one is justified in diagnosing the majority of skin lesions as eczematous or syphilitic, and while the treatment of eczema might well be considered in a separate paper, I will presume to mention a few remedies that have been of service to me during the past few years in treating some of the different varieties in which this disease appears. Eczema infantile is, by far, the most frequent cutaneous disease to which the newly born are subjected. Its lesions are so many, the treatment of each variety so different, that remedies, both local and constitutional, must be selected with gravest care. Usually, the first variety is *eczema faciei*, showing upon the cheeks and contiguous integument groups of erythematous papular lesions.

Where there exists as a causative factor impure soaps and powders, their use is to be discontinued. Where the cause can be traced to dentition, *chamomilla* 1x or 30x, combined with proper hygiene, will usually affect a cure within a short time. If, from the long-continued use of irritants, or from other causes, a semi-chronic con-

dition results, presenting lesions in various forms of development, then treatment is to be more energetic. Locally, olive oil is of the greatest therapeutic importance. Care must be taken to obtain a pure sample, since inferior preparations serve to increase irritation. Avoid plain water, since it serves to increase inflammation. Apart from symptoms, which in infants are difficult to obtain, *hepar s. c.* 6x, and *graphites* 30x, are my favorite remedies.

It must be remembered, that unless promptly controlled, the lesions will involve the forehead, ears and scalp, when we now recognize the dreaded *crusta lactea* or *eczema capitis*.

This variety of *eczema infantile* is the one that usually seeks our advice. In treating, we must not lose sight of the fact that a profound anæmic or marasmic state may arise as a result of long-continued efforts to allay itching and irritation. My routine treatment has been *hepar s. c.* 6x, one powder every three hours, and one of the preparations of cod liver oil, with locally a liberal application of olive oil. If this be ineffectual, *potass carbonas* 3j to the quart of water, used as a shampoo, will dissolve crusts, while equal parts of *bismuthi sub-nitrate*, *boracic acid* and *starch* will combat inflammation.

During my service at the Hahnemann dispensary it was my fortune to treat many such cases, and rarely have I failed to secure good results from this plan of treatment. Occasionally a complication, an *eczema parasiticum*, occurs; *ichthyol*, in the form of a wash or an ointment, is an excellent parasiticide.

Where, from the irritation of contiguous integumentary structures, an intertriginous *eczema* results, absence from the use of soap and water, and the use of *lycopodium* or *talcum powder*, is all that is needed to complete a cure.

Other things being equal, sulphur is the ideal remedy for *eczema universale*, particularly where pustules predominate, *arsenicum* being better indicated in squamous *eczemas*. It may be of interest to report, under the action of *sulphur* 200, the cure of a case of an *eczema universale* of twenty years' duration, although no portion of the integument, except the palmar and plantar regions, was exempt, the lesions disappearing within six months after the above treatment was instituted.

MEZEREUM has neuralgia in the cheek-bone, or over the left eye. The pains leave numbness. They are worse from warmth. It is especially useful when there have been herpetic eruptions after the abuse of mercury. It is one of the useful remedies for the neuralgia of *Zona*.

THE FUTURE OF HOMŒOPATHY.

BY JABEZ P. DAKE, A.M., M.D., NASHVILLE, TENN.

(An Address delivered before the World's Homœopathic Congress, Columbian Exposition, Auxiliary, at Chicago, May 31, 1893.)

Mr. President and Members of the Congress :

IN proceeding to the discussion of the topic assigned me for this occasion, I pause to remark that, expositions of the varied resources and products of nature and of art have been made in one country and another, but nowhere, and at no time, has there been one organized so well calculated to show the intellectual and moral, as well as the physical possibilities and achievements of our race, as the one in which we are now taking part.

The series of Congresses, devised by the Exposition Auxiliary for the display of the various departments of science, morality, and religion, which aim to elevate and ennoble, as well as to prolong, human life, is destined to mark a new era in the advance of civilization on the globe.

The step taken by America, in this Columbian year, towards a more free expression and interchange of views upon a recognized platform, the new beside the old and the heterodox beside the orthodox, must tend to soften harsh antagonisms and lead on to more united as well as earnest efforts for human welfare.

As we approach the end of our medical congress, held at this time in commemoration of one of the greatest events noted in history, it is well, in addition to the views and reviews relating to the past and the present, to let our mental vision run on before to see what the future has in store for the healing art.

That the condition of medicine and medical organizations is long to remain, as we see it to-day, is not to be expected nor should it be desired. Well satisfied as we may be with much in the constitution and resources of Homœopathy, we yet look forward to what is even better. It is my mission, in this brief address, to speak of some of the better things therapeutic that continued observation and experience may bring. Had I the gifts of a prophet, enabling me to look forward a few decades clearly, to discern coming changes, my task would be easy, and you would doubtless enjoy a rare intellectual treat.

THE RETROSPECT.

As it is, I must ask you, for a brief time, to cast the search-lights of memory back upon the way we have come, and the eye of observation over the fields now occupied by our school of medicine; as we can look forward only in the light of the past, calculating what will be from what has been, and what is.

The retrospect, at the outset, brings to view one great fact, never to be forgotten, namely, that the discovery of the homœopathic principle was unlike any other discovery concerned in the art of healing in that it brought to light a natural law, fixed and paramount in therapeutics. It defined the relationship that must exist between the medicinal agent and the disease to be overcome in the words, *similia similibus curantur*.

So many have been the changes for the better in the current medical teaching and practice of the world since that day it is not easy for us to realize the surprise and even consternation that prevailed upon the announcement of Hahnemann's discovery. What was then feared, in due time, became a reality—the knight of venesection and the cupping and leeching barber, and the blister-spreading and heroic dose-mixing apothecary were sent into comparative retirement.

With feelings of satisfaction we look back upon the steady development and spread of the therapeutic system based on the law of similars, especially upon its decided triumphs over such great destroyers of life as the Asiatic cholera and the yellow fever. Had it done no more to demonstrate its worth down to this time, than indubitable records show that it has done in the epidemics of those two well-marked and fatal diseases, it would deserve the confidence and esteem of the world.

The reception we see accorded to the new therapeutic doctrine by the medical men of the early part of the century was hardly such as became scientific men. The attitude of medical journalism was decidedly averse to its discussion.

Hufeland was the only editor with magnanimity and courage enough to open his pages to Hahnemann. In his journal for 1796 had appeared the dawning of Homœopathy, the first suggestion of its basic principle. But even Hufeland afterward closed his columns, in deference to the wishes of medical men, who were unable to bear the criticisms of Hahnemann, and in obedience to an authoritative medical censorship. And the prevailing policy from that time on has been either to ignore or simply ridicule Homœopathy. Hence the necessity for journals of our own, through which the new

truth could reach the profession and the public, and by which its triumphs could be made known.

But as time went on, and the followers of Hahnemann became more numerous, a curious state of things, puzzling to men of the other learned professions, developed in the ethical attitude of the dominant school.

Graduates from the old colleges were cut off from fellowship and declared no physicians because they had ventured to push their studies beyond the old curriculum and to give their patients the benefit of the farther inquiry, and some students avowing their intention, after graduation, to investigate and probably adopt the homœopathic method, were refused diplomas! Doctors, with a less complete education and a less extended medical armamentarium, assuming an attitude of superiority, refused them professional recognition and aid!

But the effect of such professional manners, while temporarily embarrassing to the ostracised physicians and their clients, was afterwards very greatly in their favor. It led on to the organization of colleges and societies devoted to the new cause, while it revealed to the public a tableau anything but creditable to the good sense of the old school—they on the one side looking down with apparent contempt on us of the other, and denouncing us as ignoramuses and quacks when possessed of the same learning as themselves, plus a knowledge of Homœopathy!

Beside individual and organized professional attacks, calling for organized means of defence, the new school had to contend, in many countries, with an unfriendly governmental censorship. Examining boards, with assumed and arbitrary standards, authorized by the state, have had a tendency to keep medical practice in old ruts; and such will always be their tendency, whether called allopathic, homœopathic or eclectic.

And great military establishments, with dictatorial surgical staffs and red-tape methods, have always been unfavorable to the careful consideration and ready adoption of new therapeutic measures. The traditional supply table for the army and navy surgeons and for hospitals under government control, have known little change from generation to generation.

Considering the influence of great standing armies and of authoritative boards of medical censors, it need not be surprising that Homœopathy has had to make its way inch by inch in Germany, Austria, Italy, France and even England. As might be expected,

the fairest field presented for its adoption and growth has been in America, away from the domination of military medical staffs and arbitrary censorships.

But our retrospect, if it shows obstacles met with, shows also advantages enjoyed in the progress of the new medical philosophy.

We see that, among medical men, not alone in this country, but in all countries, those who have been most ready to examine and adopt it have been the well educated and most enterprising. Physicians weighed down by an inordinate sense of authority and "regularity," or industriously plying their art as in a treadmill, never looking or moving about to see what may be found that is better, are not the first to appreciate what is new.

And among the people the very first to comprehend the value of curative methods based on a law of nature have been the educated and most cultured classes.

If the old medical journals were closed against us, the columns of the public press were not. If unfair representations appeared in the daily papers calculated to mislead the public and create prejudice against our cause, the opportunity was freely accorded for reply and defence.

If suits in court were instituted for our injury, judges and juries, with few exceptions, sustained us in our rights. And in matters of legislation, where efforts have been made to check our progress or curtail our freedom, law-makers have listened to our arguments and refused to deal unfairly with us.

THE PRESENT STATUS.

In surveying the present fields occupied by the new school much is to be seen that is encouraging.

There are numerous journals, in different countries and different tongues, devoted to the therapeutic measures of homœopathy, and covering likewise every department of medical and surgical inquiry. More than a score of them are issued monthly in the United States alone.

And our colleges, each with a full curriculum, and all up to the highest standard,—indeed, foremost in the extension of the general course and lengthening of annual sessions,—are a source of credit and support to our cause.

In the matter of colleges the disadvantages imposed by the censorship systems of the Old World are very plainly seen. They have prevented charters for our schools, so that we have not, to-day,

a whole school of our own in Europe possessed of the power to confer medical degrees upon its students. Even in enlightened and liberal England, our school, based on the London Homœopathic Hospital, and conducted by some of the very ablest medical men in Great Britain, cannot grant a diploma after ever so much study or upon ever so thorough and satisfactory an examination.

Hospitals and dispensaries extending the benefits of our practice to the poor are seen in nearly all parts of the enlightened world. Fortunately, boards of censors cannot always intervene between the people and the desired means of physical relief, even in despotic countries.

In its relations to other principles that have to do with the art of healing, I desire to say that homœopathy has no antagonism whatever. What surgery can and should do, or chemistry, or mechanics, to remove useless or burdensome tissues and products or destructive parasites or poisons, and what palliatives should do to save life or mitigate useless suffering, we are agreed that they shall do. We are prepared to hail with pleasure every discovery and improvement in the ways and means of preventing or removing disease.

If we hesitate, and take time to consider, when the inventions of Brown-Sequard and Koch are heralded over the world, it is for the want of more affirmative proofs of their value.

THE FUTURE.

I come now to the point where I must ask you to turn your gaze from the past and the present of homœopathy to its future.

Many and various have been the predictions made as to its destiny, some saying: "Like other popular delusions, it will have its day and pass away;" and others, "It will be the prevailing and exclusive mode of practice."

Applying analogy to the facts hurriedly passed in review, and reasoning from cause to effect, what do we really see before us? Let us consider.

Unquestionably the future has in store more exact methods of observation and clearer lines of reasoning, which must lead to a more definite understanding of the cases of disease amenable to the homœopathic remedy.

1. Taking this view my first proposition is that *the true field or sphere of the homœopathic law will be more clearly defined.*

The first and one of the most important questions presented to the physician in assuming the care of a patient is as to the particular

department of the healing art from which help must come. Is it a case for surgery, for chemical antidotes, for anti-parasitics, for change of residence, or occupation, or diet? or one admitting of palliatives only? or is it one requiring the homœopathic remedy?

It is possible for a case to require help from two or more of these departments at one and the same time.

In that case the agencies employed must be such as may co-operate with and not antagonize each other.

But, in determining the question whether a homœopathic remedy is required, the physician must very definitely and clearly understand what affections come under the homœopathic law or within its domain. It is a childish view to suppose that the physician calling himself a homœopath is, in all cases, bound only to search his *materia medica* for the remedy needed, and it is criminal for him to shut his eyes to other means, where the homœopathic remedy is not required and can do no good. Diseases, according to the help required, very readily fall into classes, and the homœopathic class is made up of all such as are similar to those producible by pathogenic means existing in organisms having the integrity of tissue and reactive power necessary to recovery, the substantial cause having been removed or having ceased to be operative in the case.

For this class the homœopathic law is supreme and universal, while for all others it has no application and no meaning.

Years ago, while lecturing upon principles and practice of medicine in Philadelphia, for convenience I divided the great field of therapeutics into two parts—general and special,—the latter embracing such cases only as call for the homœopathic remedy, and the former including all others. The special I also denominated the pathogenic, inasmuch as the curative agency in the sick was also the sick-making power in the healthy.

In truth, the different principles presiding over the several measures concerned in the restoration of the sick and the injured are complementary and not antagonistic to each other. The ardent homœopath, conscious of the transcendent value of his method, need have no fear that a strict construction of the law he rests upon and a proper recognition of its limitations will belittle its importance and weaken its hold upon the confidence of the world.

Confined to its legitimate sphere it covers ground enough and calls upon its ministers for work enough to employ the brightest intellect and most stalwart energies of a man for a very long lifetime.

2. In regard to the future of homœopathy, my second proposition is that *its basis and governing principle will survive all changes that may come, only more clearly defined and strongly established by human experience.*

It cannot in future, more than now, supply to the physician faculties to observe and note the symptoms of a case of disease on the one side nor of drugs on the other, nor can it furnish him with reasoning faculties rightly to compare them; but it most unmistakably points out the relationship between the two sets of symptoms that must be present where cures result. I can conceive of no discoveries possible, in any department of medicine, that can supersede or invalidate the truth arrived at by Hahnemann's generalization of facts and over and over again confirmed in the treatment of the sick. So long as the human organism is what it is, and the impressions of morbid causes and the resisting efforts of the vital forces are what they are, there is an everlasting necessity that the medicinal influence that proves curative shall make its impression upon the same tissues and in a manner similar to that of the morbid. That medicines acting otherwise may prove palliative or remove the *causa morbi* and thus be needed at times we do not doubt but most cheerfully acknowledge.

The whole order of man's physical nature must be reversed, so that reaction does not follow action, and so that the continuing or more lasting functional condition is not opposite to that directly induced by pathogenic agencies; if a time ever comes when the homœopathic method fails.

Terms may be changed and explanatory theories may be different, but the essential relationship between the disease and its remedy will ever be homœopathic; and I may add, that such must be the case, however the curative impression is made, whether by a single drug or a combination of drugs, by cold or heat, by electricity or massage.

3. My third proposition, as to the future is, *that the pathogenesis, or drug symptomatology constituting the homœopathic materia medica, will be more thoroughly obtained and carefully displayed.*

When Hahnemann came to understand the requirements of the homœopathic law and saw the necessity of true drug pictures, for comparison with the various disease pictures presented to the physician, he soon realized how poorly adapted to his purpose were the current works on materia medica. The most he could there learn of remedies related to their cathartic, emetic, antispasmodic and

other such general effects in the sick. Experimentation to ascertain their physiological or positive influence on the healthy human organism, had not then been started. He soon announced the necessity of proving drugs, upon the healthy instead of the sick, and himself became a prover. But poorly supplied with means and assisted at times by students of his method, he worked on with one drug after another, adding to the symptoms thus obtained what he could gather from reported cases of poisoning, till he was able to form a new materia medica, which he published in 1805 with the modest title, "*Fragmenta de viribus medicamentorum positivis.*"

Good as were the results of his work, compared with the collections in the old materia medica they yet came short of the demands of *similia*. It must ever be regretted that he allowed symptoms taken from the sick, while using remedies, to be recorded as drug symptoms. And his neglect to preserve and publish the record of each proving in the narrative form, has been a lamentable defect. His publication of drug symptoms in schematic form, disconnecting and putting them out of their natural order, left them less useful to the practitioner and the writer of materia medica than they would or should have been. In following the homœopathic principle it is often quite as important to have a similarity in the *order* as in the other qualities of the symptoms compared. With regret I mention the fact, that subsequent provers with few exceptions, possessed of superior advantages for the undertaking, have allowed the same defects to mar their work.

Only of late has there been an attempt to gather and publish our drug provings in narrative form. The British Homœopathic Medical society and the American Institute of Homœopathy, a few years ago, together, secured the publication of the *Cyclopædia of Drug Pathogenesis*, under the lead of the great materia medica scholar, Dr. Richard Hughes. The four large volumes contain all known records of reliable provings except those embraced in the *Materia Medica Pura* and *Chronic Diseases* of Hahnemann, which it was deemed best to let stand for themselves. Valuable as the *Cyclopædia* is it would have been yet more valuable had all the provings detailed been made and the symptoms recorded in a more thorough and discriminating manner. While it is the best we have it is not equal to the future best.

At this point I beg to be excused for a slight personal mention.

Just thirty-six years ago, in this city, I read a paper before the American Institute of Homœopathy, upon the defects of our patho-

genesy, and proposed for its improvement a college of drug provers—an institution under competent management, having a body of students, male and female, acting as subjects of drug influence while receiving medical instruction, during the long vacations in the ordinary medical schools; and while under expert observation, all the means for the detection and measurement of abnormalities, useful in diagnosing diseases in the sick, being employed. I showed the unavoidable defects in provings made; here, there and everywhere, by busy, wearied and worried physicians, exposed to vicissitudes of weather and sick-room influences, with little if any critical observation of their symptoms. Again and again, in after years, I urged the profession to take hold of the work and make our *materia medica* more in keeping with our matchless therapeutic law.

I am happy, on this great occasion, to say that, the tendency is now toward more thorough and careful drug experimentation, not only in our school, but in the old as well.

Dr. T. Lauder Brunton, one of the brightest of all the orthodox teachers of *materia medica* in England, writing of the therapist, not long ago said:

“Evidently, it is his especial province to find out what are the means at command, what the individual drugs in use do when put into a human system.

“It is seemingly self-evident that the physiological action of a remedy can never be made out by a study of its use in disease.”

The increasing number of liberally educated young men in our ranks, who are critical and logical, not satisfied with observations casually made and experiments not properly guarded against sources of error and corruption, look with surprise upon the rank and file of the profession apparently satisfied to go on, year after year, depending upon a hash and rehash of what was not entirely sure and reliable at the outset.

It need not be surprising if, ever and anon, some of them become disgusted with the “tithing of mint, anise and cummin” in those who are apparently heedless of the “weightier matters of the law.”

If the plan of a college of provers is Utopian, and if the influence and power of drugs cannot be ascertained by direct and scientific experimentation, we may as well consider the abandonment of drugs.

One alternative is left—if the present encouraging prospect fails and physiological laboratories and thorough provings do not come, the trade-circulars of the great drug houses, displaying the refreshing romance of clinical experience, that are being showered upon our

desks like the leaves in Vallanibrosa, may enable us to practice empiricism with some hope if with no satisfactory fruition.

But, jesting aside—the healthy vital test will not fail.

I leave its consideration, now, with the remark that, the great university that shall lead the way by devoting its entire medical department to *original research in physiology and pathogenics*, will cover its name with glory and bring to its regents and faculty, and student-experimenters the gratitude of the world during all time.

Looking again into the future of homœopathy, I remark that *some changes are to come in matters of pharmacy and posology*. While drug substance will be comminuted far enough to render its particles susceptible of absorption and conveyance to the tissues to be impressed, or to expand its surface for more ready contact; and while it will be attenuated and mixed with neutral vehicle enough to render it easy of division into proper doses, it will not be treated by bottle-washing methods in the effort to get rid of the drug altogether and secure only its disembodied spirit.

The unmerited odium that our peerless law of cure has been obliged to bear these many years by reason of the unwillingness of some of its adherents to employ the sensible doses with which the law itself was demonstrated and with which its most striking victories were won, will be wiped away.

I have now spoken of the leading changes destined to come in the interior economy of homœopathy and its practical applications, namely, *as to its legitimate domain, its persistency or permanency, its pathogenesis and its posology*.

I must now briefly refer to its future position and relations in the general medical world.

EXTERNAL RELATIONS.

It is a great mistake to suppose that homœopathy is found only in the practice of men calling themselves homœopaths.

Not only has its negative influence wrought great changes in the therapeutic measures of the masses of medical men in all enlightened countries, causing them to abandon blood-letting, blistering, and heavy doses of poisonous drugs; it has brought the most intelligent of them to prescribe many of our remedies, as we do, in obedience to the rule of similars, and in small and pleasant doses.

It has caused them to look upon the healthy human test as the proper mode for the study of drug influence in the formation of *materia medica*.

It has also led them to pay a great deal more attention to dietetics and general hygienic measures ; and why, pray, should it not do so, since they have often attributed our undeniable cures altogether to such regulations ?

Our success and evident favor among intelligent and influential people have gradually raised us in the esteem of our old-school brethren, until their society doors are open to us on the simple condition that we drop the qualifying term homœopathic from our list of titles. And we are no longer regarded as beyond the pale of professional recognition and help by reason of our additional acquirements in therapeutic knowledge !

But, putting aside all levity, we hail with satisfaction the growing acceptance of our views and adoption of our measures, and would be far from saying one word calculated to prevent so great an improvement in the current medical practice and such positive benefits to the sick under its care.

We do not insist upon their calling themselves homœopaths in order to enjoy the use of remedies that we know cure homœopathically ; nor, on the other hand, do we see any occasion for us to drop that title from our institutions because we recognize and employ, now as always, surgical, chemical, mechanical and other means which are neither homœopathic nor allopathic. I fail to see why we should be any the worse for the use of a name that indicates very correctly our confidence in the principle *similia*, when no medical man can be so ignorant as to suppose that we do not understand and follow other principles and use other measures as occasion may demand.

In conclusion, upon our future name and relations, I would say that, when the right of every educated physician to choose his method and means of cure, becomes generally recognized, and his privilege to candidly state his views and temperately criticise the views of others on the floor of any medical society, or in any medical journal, is accorded without reproach or abuse—then, and not before, may it be expected that the societies and institutions of the new school will be disbanded or known by no distinctive sectarian title.

It cannot be forgotten that, our organizations, our journals, colleges, hospitals and dispensaries were matters of necessity for the maintenance of our freedom to choose and apply the new therapeutic measures and to extend their benefits to suffering humanity.

But for them the most important reform in the art of healing now enjoyed would have been arrested at the start.

With the freedom existing in associations for scientific research and the promotion of social reforms, where each idea and proposition may have a hearing and due consideration, there would be no excuse for different schools or separate organizations in medicine. The only unity possible among medical men and medical associations will be the kind that consists with *diversity* and with the liberty, on all sides, to think and work, with all due respect, each on his own lines. Physicians should be as free to criticize each other's opinions and measures as are lawyers, whose sharp contests make them none the less personal friends to each other and none the less worthy members of the bar.

As matters stand, the right forward step to secure unity is one of common politeness, by one medical man toward another, and by one association towards others. It requires no disagreeable concession or damaging compromise, for one to treat another with the courtesy due among men equally educated and equally devoted to the same cause.

There needs to come among us a Y. M. M. A.—a Young Men's Medical Association, that, like the "Y.M.C.A.," can practically solve the great problem of *unity in diversity* and secure working relations between medical men and medical organizations which, with a common purpose in view, are now moving forward on different lines.

A special dispensation of mercy alone can save us, if we are more bigoted and touchy, or have less of practical sense than the religious sects that the Christian young men are, even now, gradually pulling together.

THE TREATMENT OF EPILEPSY, IDIOCY AND ALLIED DISORDERS BY CRANIAL EXCISION AND INCISION.

BY G. F. SHEARS, M.D., CHICAGO, ILL.

(Read before the Congress of Homœopathic Physicians and Surgeons, Chicago, May 30, 1893.)

At the annual meeting of the American Institute of Homœopathy, held in 1889, the Surgical Bureau took for its topic Brain Surgery, and presented exhaustive treatises covering almost every phase of this subject.

I do not intend in this brief article to compete with the report there submitted, but rather to supplement several divisions of the subject, by considering the present position of certain surgical pro-

cedures and by presenting some personal experience. In no other department of surgery, not excepting the surgery of the abdomen, have more new methods been introduced or more startling innovations than in brain surgery and a large part of this history has been made within the last few years.

The time is so brief that much of the work done has not been recorded and sufficient data is not at hand to determine its value or its attendant dangers. It is only by the trial and comparison of the results obtained that the true value can be determined. It is the duty then of every one to record his results and thus contribute the more rapidly to a safe surgical practice, for surgical practice is the result of the consensus of surgical opinion rather than the practice of one man, as Nancrede aptly puts it. It is in this spirit that I review the disorders which have been selected as the subject of this paper and append thereto some surgical cases. The disorders selected are epilepsy, cephalalgia, paralysis, insanity and microcephaly.

Epilepsy.—Removal of a portion of the cranium for traumatic epilepsy is not a new operation. In 1705 La Motte made, I believe, the first recorded operation. From that time for almost one hundred years the operation languished. Although made from time to time during the earlier part of the present century it was not until the advent of antiseptic surgery and the closer study of cerebral localization that it began to be generally employed. Even during this period the operation was confined to such cases of traumatic epilepsy as were accompanied by marked depression of the cranium and in which the history of a compound fracture was undoubted. Within the last four or five years the sphere of the operation has been extended and operations have been made upon non-traumatic cases classed under the head of Jacksonian and focal epilepsy.

Some of the more venturesome have even advocated the use of the trephine in general epilepsy—if such a term may be employed. It is in *traumatic* cases in which a decided depression is present that the greatest number of operations have been made and in which the best opportunity for determining the value of an operation exists, yet medical opinion differs widely as to the ultimate result of the procedure. Dr. O. Laurient reports one hundred and two cases of trephining for traumatic epilepsy; 54 per cent. cured, 17 per cent. unimproved, 20 per cent. improved, 2 per cent. worse, 7 per cent. died.

Agnew, in his review of work of Philadelphia surgeons, in which I see no notice is taken of the work of surgeons of the homœopathic school, reports fifty-four cases, of which thirty-two experienced tem-

porary benefit, nine no relief, four passed out of observation, four cured and four died. Briggs reports from Stephen Smith's table ninety-two American operations with sixty-three cures, from Bartholomew Hospital reports one hundred and thirty cases—seventy-five cures, and of his own thirty cases with twenty-five cures. Personally I report the following cases:

CASE I.—Young man *æt.* twenty-nine years; nine years before had been kicked by a horse in the forehead, sustaining a compound fracture; three years later he was badly scared; this was followed by convulsions which gradually ceased; four years later convulsions returned and at the time of the examination had continued two years, occurring regularly two or three times a week. The depression was found in the left frontal region beginning two inches above the supraorbital ridge and extending two and a half inches upward toward the median line. The entire depressed bone was removed. It was closely adherent to the superior longitudinal sinus and was dissected off with the knife. During the operation the sinus was punctured and for a time the hæmorrhage was profuse. It was controlled by sponge pressure and eventually by suturing with catgut. Convulsions ceased after the operation and did not return for six months. At the end of that time he began drinking heavily and the convulsions returned. Upon stopping the use of alcohol they ceased.

CASE II.—Man, *æt.* 42 years; five years previous was struck by a locomotive, sustaining a fracture of the right parietal bone, also severe injuries and possibly fracture at some other point of the cranium. The patient remained in a comatose condition for three weeks and did not fully recover consciousness for six weeks. All previous knowledge was obliterated. Three years after the injury, he began having convulsions two or three times a week. The spasms were ushered in by the patient turning to the right, then the head turned toward the right followed by contractions of the right forefinger and thumb, then the arm, face and leg. An irregular depression was found on the right side about two inches above the ear. Some question arose as to the best locality to trephine. Although the depression was found on the right side, the symptoms seemed to indicate an irritation of the left motor tract. The history was of little assistance. For some time after the injury the patient was in such a critical state that he was expected to die every moment and a careful examination was not made. Severe contusions were found all over the head, any one of which might have been accompanied by a

fracture. It was therefore decided to make the operation over the depressed bone. The entire area was removed. The dura was much thickened and inflamed. The patient did well for a few weeks, having no convulsions. Subsequently they returned with full force.

CASE III.—Young man æt. 30 years; three years before was struck on the head with a hammer; wound never healed completely, a fistulous opening remaining. Two years after the injury, convulsions began and continued until the present time. They occurred two or three times a month, the patient remaining unconscious for half an hour after each one. The frontal bone was uncovered and a small fistulous tract was found under it. The trephine was applied at its upper portion and a small sequestrum and pus sac found on its under surface, both outside the dura. They were removed. No convulsions occurred for one year, when the patient was lost sight of.

CASE IV.—Man, æt. 39 years, kicked by a horse in the left frontal region, producing a compound linear fracture; the patient never lost consciousness; the wound healed promptly. Three weeks later had a convulsion, followed in two weeks by another. Trephining was performed over the seat of injury. The bone was not depressed, but a thin blood clot was found between the skull and the dura. This was removed. The patient made a prompt recovery. No convulsions have since occurred.

CASE V.—Man, æt. 46 years. Fifteen years ago a trap door fell on him, striking his head a little to the left of the median line, producing a contusion of the left parietal bone. The skin was not broken. The spot has remained sensitive and the skull seems more prominent at this point. Five years ago he began to have a twitching of the right arm. He loses consciousness but does not fall. The sensitive part was exposed and the one inch trephine employed. The bone was found to be very hard and much thickened. No diploe existed. No depression was discernible and the membranes seemed normal. The patient recovered and was free from the convulsions when last heard from, three months after the operation.

Jacksonian Epilepsy.—In this form of epilepsy the convulsions are confined to a single group of muscles, and are not accompanied by loss of consciousness. Whether the cause is largely traumatic or idiopathic is not known; that some cases are due to cerebral traumatism seems certain, but, that others have no such history, seems equally positive. The limited muscular involvement indicates that the brain-lesion is of limited extent. Our study of brain localiza-

tion enables us to locate the centres involved. Very naturally, the thought arises, that if the irritant, in the shape of a scar, or, in non-traumatic cases the irritable centre, were removed, the spasm might be prevented. The plan has been carried into execution ; but, while the theory is simple, and upon first thought it would seem the plan should be followed by good results, there are certain reasons why the prospect of a cure by operation, in this form of epilepsy, is not encouraging. In those cases in which no lesion is apparent, our present knowledge is not sufficient to locate the real cause of the trouble. Even if we locate, approximately, the discharging centre according to the rules of cerebral localization, and by means of the electrode applied to the cortex of the brain determine the exact centre of discharge, we have no assurance that the irritation which causes the discharge is in the centre itself, and that its removal will remove the irritation. In those cases in which a real lesion exists, as shown by cicatricial tissue, the removal of the same might be followed by relief. Even in these cases, the healing is necessarily followed by a scar, which, in all probability, will give rise to the same irritation as before. That many more cases are due to traumatism than is generally admitted, I have no doubt. In this connection, an interesting article by Dr. Ira Van Gieson, showing the changes that had taken place in the brain, as proven by the microscope, in the case of a patient who had had epilepsy as the result of a skull injury, but in which there was no fracture of the inner table, could not but make me consider how many opportunities there are for brain traumatism in the injuries of childhood, even where fracture does not occur, and that possibly many cases usually considered as idiopathic may be, in truth, traumatic. In seventeen cases of Jacksonian epilepsy, which I have collected in my reading, only three are reported as cured. Two of them were from traumatic causes, and were only a short time under observation. The mortality was large, about 47 per cent. My own experience is limited to the following case, in which a complete operation was not made :

Girl, *æt.* 17 years ; convulsions occurred two or three times a week, commencing in the hand, and then extending to the neck, ending with a wagging motion of the jaw. No history of fracture of the cranium could be elicited, and no scar could be found upon the scalp. The mother remembered, however, that the girl had fallen down stairs six or seven years before, and had complained for a long time of a pain in her head. Believing that a more severe injury had taken place than was at first supposed, and with the determination

that if any visible lesion existed, that the discharging centre should be removed, an operation was advised. The symptoms indicated the irritable centre to be the middle third of the ascending frontal convolution, and, accordingly, the trephine was placed a little in front of the middle third of the fissure of Rolando; the method employed to determine this line being that recommended by Professor Chiene. Although the dura was incised, and the brain carefully examined, no scar nor inflammatory patch could be found. The removal of brain substance was, therefore, abandoned, and the wound closed in the usual manner. To my delight, the patient had no more convulsions while under my charge, some three weeks. Whether this result was due to shock, relief of intercranial pressure, or the removal of some irritable point in the skull, I do not know.

Cephalalgia.—The results of operations undertaken for this disorder, when due to traumatic causes, are very encouraging, both as regards benefits derived and the slight mortality of the operation, if we may depend upon the reports made in our medical literature. Of some twenty cases which I have noticed in my reading, relief was obtained in all, even in those in which no appreciable lesion could be found. How permanent the result could not be determined. The following case, published some time ago in the *Clinique*, is the only patient upon whom I have made the operation:

A young man, æt. 23 years, was struck on the head with a stick, sustaining a scalp wound. For twelve weeks was never in full possession of his faculties; was violent, and for six weeks in an insane asylum. A discharge of pus relieved the insanity (*Clinique*, vol. xiii., p. 518) but headache remains; cannot focus the eyes; is unable to follow his business. The cicatricial tissue was excised from the scalp with the hope that this would relieve the irritation, but no relief was obtained. The scalp was sensitive for some distance around the scar. The scar was excised, and the periosteum underneath it, which was adherent, also excised, and a button of bone removed from the sensitive area. No thickening of the bone or lesion of the dura was discovered, and yet a perfect cure followed. In a somewhat similar case, reported by me in the *Clinique*, but not reported under this head because there was no operation made upon the bone, the headache was relieved by the removal of the scar, but in the above case the removal of the scar alone failed to effect a cure.

Insanity.—Excision of bone or trephining for insanity is an operation which has rarely been done. That such an operation is war-

ranted when the insanity follows a depressed fracture, rests upon the same basis as that of the operation for epilepsy, yet, although the number of cases of insanity following fracture is considerable, I was surprised to find that few cases of operation for the relief of insanity are on record. Prof. Briggs reports two cases, one of which died and the other improved. Dr. Boyd reports one case with no improvement, and two other cases reported in journals were quoted as not improved. The most favorable cases are those in which depression is present, and some symptoms indicating local pressure are prominent. My only operation for this trouble is recorded in the following case:

Young man, æt. 22 years. Four years previous was kicked by an unshod horse, cutting a gash about two inches long nearly transversely across the posterior portion of the right parietal bone. It was not determined at the time whether the bone was fractured. The patient was unconscious for four hours after the accident. Three months later the first symptoms of insanity were noticed. He would mutter and gesticulate while at work, and when unemployed was restless and irritable. For some time previous to his being brought under my care he had been violently insane. No appreciable indentation of the skull could be found. The seat of injury was uncovered by a horseshoe-shaped incision; the old cicatrice excised and a button of bone removed from the cranium just under the scalp wound. No indentation of the internal plate was noticed. The dura seemed normal, and upon opening it and examining the cortex no injury could be detected. The patient made a good recovery, but the only benefit was an increased tractability and a lessened violence. This condition remained three months after the operation.

Paralysis.—Local paralysis following injury to the skull has been treated by excision of the depressed bone, although the number of such cases recorded are very few. In general paralysis operative treatment has been believed to be of no service. Rey argues that in the early period of general paralysis the intense congestion increases the volume of the brain as well as diminishes the endocranial cavity by thickening bone. The removal of the resulting compression by an opening at some point may set aside some of the general phenomena, but in confirmed cases surgical interference would be powerless to hinder the change due to chronic meningic encephalitis. The following case was operated upon by me December 19, 1892:

Man, aged 41. Fifteen months previous was struck on the right

parietal bone with an axe. The exact extent of the injury was unknown. Eight months later he began to feel a numbness in the left arm and leg, accompanied by some impairment of motion. This increased rapidly, until in a short time he was confined to his bed. He lost the power of speech, control of the urine and fæces. About three months before I saw him the right leg and arm commenced to jerk. Prof. Fellows saw him in consultation with his physician, and saw no hope of benefit unless it might result from operative interference. When seen by me the left side was paralyzed, the arm completely, the leg partially; the right arm and leg were in a state of contraction; the head and body inclined to the right side; swallowing difficult; eyes unaffected; conscious, but could not speak. The progress of symptoms indicated to my mind a lesion in the right motor area extending over into the left, presumably meningis-encephalitis. The lesion seemed so extensive that an operation was not advised, but the friends were so anxious that some effort should be made that, with the hope that pathological changes might be limited to the right side, and the symptoms of left side involvement might be due to sympathy, an operation was attempted. A large button was removed from the upper portion of the right motor tract, and the dura found to be very much thickened and so full of bloodvessels that for a time it was supposed a new growth was present. The opening was rapidly enlarged with the cutting forceps, and a large area exposed extending over the median line. The inflamed dura extended over into the left motor tract. The dura was incised and the cortex examined. The pia mater, while not adherent, was inflamed, and the cortex of the brain had a yellowish hue. While separating the inflamed dura from the cranium, a large vein close to its entrance into the superior longitudinal sinus was opened, and hæmorrhage was profuse. It was controlled by pressure, and subsequently by ligation. The patient never fully recovered from the shock of the operation, and died twenty-four hours later.

Microcephaly.—One of the most unpromising conditions which has recently been attacked by the surgeon is that known as microcephalic idiocy. It is believed that a certain number of cases of idiocy may be due to the pressure of a prematurely ossified cranium. In these cases Lannelongue proposed and has practiced the excision of a groove in the skull in order to permit of brain expansion. He reports twenty-five cases; one case died; most of the remaining showed marked improvement. My own experience is confined to the following case:

Girl, aged 6 years, idiotic, cannot walk ; moves a few steps and falls ; cannot stand still without support. Has no control over the urine or feces ; cannot talk or make known her wants except by screaming ; eyes convergent. Has no decided convulsions, but at times very restless and excited. Head is irregular in shape and noticeable for its lack of frontal development. No cause could be assigned by the parents. At birth labor was normal, except that it was a footling instead of a cephalic presentation. Do not know whether the fontanelles closed early or not. Following the plan suggested by Lannelongue, a section of bone three-eighths of an inch wide and extending in a curvilinear line from a little to the left of the occipital eminence to a point a little below the frontal eminence, was excised. By this means a long, flat, U-shaped, with the base below, was formed over the whole motor tract. The wound healed promptly, and the child at once showed signs of improvement. Three months after she had control of urine and feces, was able to walk and use three words. More than this could hardly be expected in so short a time.

A review of my work shows five cases of traumatic epilepsy with four successes and one failure, one case of Jacksonian epilepsy with one success, one case of cephalalgia with complete relief of the symptoms, one case of insanity not improved, one case of paralysis with one death and one case of microcephalous with decided improvement. In the fatal case the result was due to the shock of operation during the active progress of encephalitis, and in estimating the dangers of operative interference in non-inflammatory cases such as epilepsy, cephalalgia and microcephaly ought not to be taken into consideration. In the other cases no evidence of a serious operation having been made was evinced. In every instance the wound healed with suppuration, the patients were up at the end of one week and often discharged at the end of two. Indeed, I know of no operation in which so rapid recovery takes place, and I am inclined to believe with Dr. Roberts, who expressed himself some time ago before the American Surgical Association to the effect that the operation of trephining added no more risk than the amputation of a finger.

A consideration of my own cases and a careful reading of the results obtained by others lead me to several conclusions :

1. That after a careful removal of all other exciting causes that may produce epilepsy, cephalalgia, paralysis or insanity, especially when a history of cranial injury is obtained, the surgeon is in duty bound to attempt the removal of this possible exciting cause.

2. That there is a good probability of success attending his efforts in traumatic epilepsy, cephalalgia and localized paralysis and in lesser degrees in insanity. In this connection it must be remembered that in the production of these brain disorders there are two conditions present, an acquired or hereditary abnormal excitability of the reflex centres and a peripheral irritation from depressed bone, inflamed dura, clot or scar. The removal of the exciting cause leaves still the acquired abnormal excitability of the reflex centres and some other irritation may occasionally reproduce the convulsion. Again, this habit once acquired becomes in a degree independent of the original lesion. For this reason one must not be discouraged or determine the operation a failure if convulsions do not immediately cease. The anatomical cause may be removed, but therapeutic measures are still necessary to remove the tendency. Many cases given up as failures might have been classed as successes if careful treatment had followed the operative procedure. The earlier, then, the operation, the the less the probability of an acquired habit and the greater the prospect of success.

3. That the operation for microcephalic idiocy is still an experiment but one that considering the deplorable condition of the patient and a little risk undertaken warrants further trial. Although possibly not a logical conclusion from the consideration of the treatment of epilepsy, idiocy and allied disorders as outlined in the cases reported, I have been deeply impressed with the fact that so many cases report an imperfect examination of the original cranial injury, and I feel warranted in advising in the interest of primitive measures a bolder treatment of cranial injuries. It may have been wisest before the time of antiseptic surgery to treat all cases, except those showing evidence of compression, by conservative measures, but with our present methods and basing my conclusions on the excellent results that have followed this plan of treatment in my own practice, I feel it my duty to urge thorough examination and trephining in all cases of fracture of the cranium attended with depression, and in all compound fractures, whether accompanied by depression or not. It may not be inappropriate to add a few words regarding the technique of the operation. It is my custom to shave the entire scalp, scrub it with soap and water, wash the skin with ether, then bathe with a one to two thousand solution of bichloride of mercury and apply a skull cap of gauze, wet in the solution and covered with gutta-percha tissue. This is done 24 hours before the operation and the dressing left until the moment of operating. I

invariably use chloroform unless contra-indicated by some trouble as an anæsthetic, as there is, I believe, less venous congestion and less hæmorrhage. The opening is made with the trephine and subsequently enlarged with the cutting forceps or chisel. If upon the removal of the bone the brain pulsates naturally and the dura appears normal, the latter is not incised. If, however, the dura is inflamed, if pulsations are absent, or if there is no cranial lesion to account for the trouble, the dura is incised about a quarter of an inch from the bony boundary and the brain examined. Until the excising of the dura the bichloride solution is used. I have, however, used the one to two thousand solution in accident cases in which the brain substance was exposed with no bad effects. Before closing the scalp the dura is united by catgut sutures and rubber drainage-tubes placed between the dura and the scalp. If there is any tension from the excision of the scalp scar the scalp is united by silver wire sutures rather than with catgut. A simple dressing of iodoform and sterilized gauze is employed; no ice cups or lotions are applied. The wound is dressed in 24 hours and not again until the seventh day. I do not replace the bone discs or chips, believing that we desire to remove all possible sources of irritation.

TREMOR.

BY CLARENCE BARTLETT, M.D., PHILADELPHIA.

Definition.—Tremor consists of involuntary oscillatory movements, which are produced by more or less rhythmical alternate contractions and relaxations of antagonistic muscles. It is to be distinguished from fibrillary contractions, a condition characterized by alternate contractions and relaxations of individual bundles of muscular fibres, manifested, not by gross movements of the parts to which the affected muscles are attached, but by wavy subcutaneous oscillations of the fibres involved. Nor should tremor be confounded with muscular twitchings, the muscular contractions in the latter being more decided and less persistent. Clonic movements arising from tension on tendons in cases in which the deep reflexes are greatly in excess, have been erroneously denominated tremor by some; many of the so-called tremors in spinal and cerebral syphilis and after hemiplegia are undoubtedly of this class.

There are certain characteristics in every case of tremor that should be carefully noted. They are: 1. The amplitude of the tremor, whether the movements are fine and coarse. 2. The rapidity and regularity of the movements. 3. The regularity of the tremor and the influence exerted upon it by certain external agencies, as rest, voluntary movements, sleep, massage, etc. 4. Its distribution, for it may be limited to single parts or limbs, or to one lateral half of the body; or again it may be of universal distribution.

It has been customary for years, in treating of the subject of tremor to divide cases of it into two great classes, one, *tremor coactus*, in which the movements persist during repose; and the other, *tremor a debilitate*, in which they are observed only during efforts at voluntary movement. In my opinion this classification is not as valuable, clinically, as we have been led to believe, for many of the cases of tremor assigned to the former class, have the characteristics of the latter, and *vice versa*. Regarding the different influences which ameliorate tremulous movements, there is one that I do not find mentioned at all in any literature at my disposal. I refer to massage. Several cases of most aggravated tremor have shown a cessation of the tremor for several seconds following manipulation of the muscles involved, or pressure upon certain portions of the trembling extremity. None of these cases were hysterical.

Tremors persisting during rest are typified in paralysis agitans; in fact this disease is almost the only one in which the movements cease during voluntary movements. Tremors arising from senility, toxic influences, asthenia, hysteria, disseminated sclerosis, and organic disease of the brain, are mostly observed during attempts at voluntary motion. Cases of paroxysmal and epileptic tremor cannot be assigned to either class. They are distinguished from all others in that they occur under such conditions as to make the execution of voluntary movements impossible.

I shall treat of the various forms of tremors under the following heads:

1. Simple tremor, including the so-called essential tremor, and cases arising from hereditary transmission.

2. Senile tremor.

3. Asthenic tremor.

4. Hysterical tremor.

5. Toxic tremor, which may arise from exposure to the following poisons:

- a. Lead.
- b. Tobacco.
- c. Mercury.
- d. Alcohol.
- e. Chloral.
- f. Opium.
- g. Tea, coffee, etc.
- h. Uræmia.

6. Tremor symptomatic of or associated with the following named diseases :

- a. Exophthalmic goitre.
 - b. Writer's cramp.
 - c. Epilepsy.
 - d. General paralysis of the insane.
 - e. Disseminated sclerosis.
 - f. Paralysis agitans.
 - g. Tumor of the brain.
7. Post-paralytic tremor.
8. Paroxysmal tremor.

In the above classification no mention has been made of acute or transient tremors, such as those arising in the so-called healthy as a result of physical or mental strain, exposure to cold, etc. The nature of tremors arising from these causes is readily recognized by the merest tyro, and their consideration is unnecessary because they are of so short duration as to rarely, if ever, be brought to the attention of physicians.

Simple tremor includes all those cases in which the tremor occurs without apparent cause, or is unassociated with other evidences of ill-health. In many instances it has shown a remarkable tendency to occur in families, so much so in fact as to lead some authors to establish a separate class called hereditary tremor. In all these cases the tremulous movements are very fine and generally regular as to their amplitude and rhythm. They are for a time under the control of the will. While intensified during voluntary movements, they do not interfere in the least with the execution of the same. The patient can perform such complex movements as writing without difficulty. Though not necessarily so, the tremor is limited to the hands and head. It affects mostly the young and middle-aged. It is very intractable to treatment. Once it has thoroughly established itself, it persists throughout life. Some tremors occurring in children born of nervous mothers disappear spontaneously or under treatment after a few years.

The hereditary tendency to tremor displayed by some families is truly remarkable. Thus, in a case reported by Dr. Samuel West (*British Medical Journal*, April 17, 1886, p. 744), the patient's grandmother and mother had been affected. He was one of ten children, all of whom suffered from tremor varying in degree, and the affliction had been reproduced in his own six children.

Senile tremor appears in people of advanced years and in the prematurely aged. It presents points of similarity to each of several varieties of tremor. It is a fine tremor, aggravated by movement, beginning usually in the head and neck, the arms and hands being attacked after the trouble has lasted some time. Clinically, it is especially apt to be confounded with paralysis agitans. In the latter the tremor is present when the hands are at rest, the movements usually begin in the hands, while the head and neck are generally free, and the tremulous parts are affected with a peculiar rigidity.

Asthenic tremor has all the characteristics of the simple variety, but differs from it in having a well-defined relation to certain asthenic conditions. It is especially liable to occur after exhausting diseases, as the specific fevers, in cases of nervous exhaustion, and after hæmorrhages and sexual excesses. Many of the cases of tremor in young males arise from the latter cause. The tremulous movements occurring during the course of diseases other than of the nervous system are of the asthenic variety. They are significant only of the extreme debility present.

Hysterical tremors are exceedingly irregular in every respect. They may be fine or coarse, rapid or slow, mild or severe, and these in the one patient. Their distribution is as varied as their character. They may be hemiplegic, or they may invade the entire body, or they may be limited to but one limb or to one group of muscles. The movements are intensified during the execution of voluntary movements, but, as a rule, the aggravation does not begin immediately after the movements are commenced, usually not asserting itself until muscular action has been maintained for some little time. Hysterical tremor is almost always increased when attention is directed to it, and ceases when the mind is diverted. It may in some cases be associated with paralyses and contractures. When the limbs are the seat of contracture, the tremor is excited by any attempt to move them passively or even by the manipulation necessary during a medical examination. A long duration (*e.g.*, many months) does not contra-indicate the hysterical nature of a given tremor.

As already stated, chronic tremors may be produced by exposure to certain poisons, as lead, mercury, tobacco, alcohol, tea, coffee, chloral, opium, etc. There is little to say that is diagnostic concerning tremors arising from exposure to these poisons. They are all fine tremors, usually intensified during voluntary movements. Saturnine tremor is usually limited to the face and hands. Occasionally, it is very acute and violent. It is aggravated after prolonged exercise, or in the latter part of the day, when the muscular system is exhausted. The diagnosis depends upon a history of exposure to lead poisoning, the previous existence of lead colic, blue line on the gums, anæmia, wrist drop, etc.

Tremor is of far more frequent occurrence in cases of poisoning by mercury than by the metal above mentioned. It usually begins in the face and tongue, and is always intensified by any motion. In its incipient stages, it occurs only during voluntary movements, but later it becomes constant, in which case it presents a remarkable similarity to paralysis agitans. Articulation is very much interfered with. In some cases, the tremor is of sudden onset. The diagnosis rests upon the known exposure to fumes of mercury, and upon the associated symptoms. A very interesting, as well as rather unusual case of mercurial tremor has been reported by Letulle (*La France Med.*, November 8 and 10, 1888; abstracted in the *Medical Analectic*, February 28, 1889.) A man æt. 39 years, had been exposed to the fumes of mercury for many years. In his first attack of tremors, the movements were worse in the morning, and again much relieved between the hours of 4 and 5 P.M., and again very marked in the evening. One day the tremors suddenly became very violent, so much so in fact that the man was thrown down by them, and convulsed, so that he could not walk. When perfectly at rest in bed the movements were but slight; but they were very much intensified by voluntary effort. Motions were extensive, rapid and arrhythmical, and worse on the left side. An anæsthetic area was discovered on the back of the right forearm and hand. Vision had become impaired. Constricting the limb lessened the tremor. Finally the tremor was stopped permanently by ligaturing the limb, and passes with a magnet. The author called it a case of mercurial hysteria.

Acute and chronic alcoholism are almost always attended by tremor of some kind, noticeable usually in the arms, face and tongue, often associated with local muscular twitchings. In severe cases the latter amount almost to shock-like muscular contractions. The alco-

holic tremor is especially apt to be worse in the morning, and is promptly relieved by a drink of whisky. The restlessness of alcoholic subjects makes the tremor very prominent.

Tremor is not a common symptom of the chloral habit. When it occurs as a result of chloral or opium addiction, it resembles in every way that arising from alcohol.

The tremor arising from excessive use of tobacco, coffee, tea, etc., is of very fine character, apparently presenting no distinctions from simple tremor.

Charcot has described a form of tremor closely resembling that of paralysis agitans, due to uræmia.

Tremor is met with as a prominent symptom in quite a variety of diseases. In *exophthalmic goitre* it is rarely absent. It is generally not of a severe grade, usually being mentioned by the patient as a nervousness, and observed by the physician as an exceedingly fine tremulous movement. Still it may be of variable character. Sometimes it is so violent, and regular as to resemble that of paralysis agitans. It may be general or again confined to the hands alone, or even accompanied by fibrillary contraction of the muscles of the face. This fact must be borne in mind lest a diagnosis of general paralysis be not too hastily made, especial as exophthalmic goitre is not infrequently associated with mental symptoms. The usual mental anomaly, however, is melancholia, or melancholia alternating with periods of considerable excitement. (*Medical Record*, xi., p. 52.) It has been known to be unilateral in distribution, when the exophthalmus or the goitre was one-sided.

Tremor is occasionally met with as the almost exclusive manifestation of *writer's cramp*. It is then most marked in the forefinger when the hand is at rest, and the fingers slightly separated. It is especially apt to be produced by prolonged work and over-fatigue.

Rare cases of *epilepsy* are met with in which the seizures are preceded by a general or localized tremor as a kind of aura, or as in one of my patients, tremor took the place of the convulsions. Gowers holds that "fits" ushered in by tremor are almost always epileptic, and not hysterical.

General paralysis of the insane in its earliest stages presents more or less tremor. The movements are especially marked in the tongue and lips, less so in the fingers. Speech becomes hesitating and drawling, with a tendency to slur words. Its relation to the severity of other symptoms is decidedly irregular. In the final stages of the disease, violent tremor accompanies every voluntary movement.

Disseminated sclerosis and *paralysis agitans* are, of all diseases, the most constantly associated with tremor; in fact we might call tremor a necessary part of their symptomatology. These diseases have a well-defined clinical course, the consideration of which requires more time than is permissible in the present article.

Some cases of *brain tumor* present tremor as a prominent system. Usually, it has but little significance. Sometimes, however, pressure of a cerebellar tumor upon the pons varolii or medulla oblongata, or of a tumor of the centrum ovale upon the fibres of the internal capsule causes a persistent tremor. In a case of cerebellar tumor (sarcoma of the dura mater) under my care, and in which there was marked irritation of the pons, there were repeated paroxysms of tremor, limited to the arm on the side opposite to the lesion. The attacks lasted all the way from a few hours to a day or more.

Following paralytic seizures, we sometimes have a tremor affecting the paralyzed extremities. This varies in different cases. Sometimes its character is such as to lead to its being called post-paralytic chorea.

Paroxysmal tremors have been described by different authors. Suckling (*British Medical Journal*, March 23, 1889, p. 656) reports the case of a laborer, aged 60 years, who for two years had suffered from attacks of tremor of the right upper extremity. Attacks were induced by sudden noises or shocks. The movements were limited to the right upper extremity only. They were of great amplitude, and consisted of very rapid flexion and extension of the forearm, which could not be controlled voluntarily or by force. There was no aura preceding the attack, but coincidently with the onset of the tremor, the patient had pain in the upper part of the right thigh. There was no loss of power in the right arm or leg, and no alteration in the reflexes. The attacks ceased abruptly and spontaneously, as the patient said, with a snap. Dr. Suckling expressed the opinion that the tremor would eventually become continuous, and the case end in *paralysis agitans*.

The convulsive tremor of Hammond, described by him in 1867 (and in his work on *Nervous Diseases*, 1886), as including those cases of non-rhythmical tremor or clonic convulsive seizures which are unattended with loss of consciousness, but which, nevertheless, are paroxysmal in character, in the light of modern neurology requires no consideration. They may all, or nearly all of them, be relegated to various forms of tolerably well understood nervous conditions, without the necessity of manufacturing a new disease.

As to the possibility of simulation of tremor, I believe that it can be done, and think that I have seen one such case, one in which the movements were limited to one arm, and which ceased on the recovery of substantial damages.

Paramyoclonus multiplex is probably better included under the tremors than elsewhere. It is an exceedingly rare disease, not more than a dozen cases of the same having been reported. It is characterized by paroxysmal clonic movements, symmetrically distributed in muscles, or groups of muscles, of which one extremity has an attachment to the trunk. The muscles of the forearms, wrists, and hands, and legs and feet, are not affected. The majority of cases occur in males. The prognosis is favorable, although the disease runs a slow course.

A CASE OF EMPYEMA AFTER TYPHOID FEVER.—Dr. Weintraud records the case of a 19-year old man who was exceptionally slow in recovering from an attack of typhoid fever. A puncture in the seventh intercostal space, posteriorly, revealed pus of a yellowish color, viscid and muco-purulent, in which typhoid bacilli were found and cultivated. After two trial punctures and symptoms of perforation into the abdominal cavity had supervened, he, in two and a half weeks, rapidly recovered his health, without surgical interference. This observation, together with others reported by various writers, show that not all cases of pleuritis, from pyogenic micro-organisms go on to suppuration. Experience teaches that pneumococcic empyemata generally run a favorable course and do not require operative interference.—*Berliner Klin. Wochenschrift*, No. 15, 1893.

SKIN AFFECTIONS IN THEIR RELATION TO INTESTINAL AFFECTIONS.—Dr. Ehrmann finds the liability of persons to eczema to differ. Dyspeptics easily contract this disease. The vesicular eczema of the palms and soles of tubic patients is of direct nervous origin. Patients with hæmorrhoids easily have anal eczema which by scratching is scattered over the entire body and thus becomes universal. Urticaria follows absorption of toxic albuminates as bee-poison, that of certain foods, in habitual constipation, after the contents of certain cysts have flowed into the abdominal cavity as ovarian and echinococcus cysts. The odor of certain foods (strawberries), will also as well as psychic influences cause urticaria.—*Wiener Mediz. Presse*, No. 17, 1893.

SYPHILITIC SPINAL PARALYSIS AND ALLIED FORMS.—Dr. Kuh finds besides tabes dorsalis one form of transverse myelitis to be of syphilitic origin. It is characterized by spastic paresis and slight disturbances of sensation in the lower limbs, distinct involvement of the bladder and slight muscular tension, in spite of increased tendinous reflexes. The writer compiles the known cases where diagnosis was certain (62) and enlarges the clinical picture. The differentiation spastic spinal paralysis has no vesical nor sensory disturbances, ordinary dorsal myelitis presents no remissions, continual muscular spasms and atrophies, while in the syphilitic forms remissions and intercurrent improvement are not infrequent. Contrary to tabes dorsalis it appears a few years after infection. The seat of the disease is in the dorsal cord, the posterior and lateral columns being chiefly and extensively affected. Changes in the vessels are at the bottom of the process. In rare cases the cervical or lumbar cord may be affected instead, while the clinical manifestations will change according to the localization. In the first form diagnosis is only to be made with certainty. In all cases an energetic course of inunction is of great service.—*Deutsche Zeitschrift fuer Nervenheilkunde*, 1893, Bd. iii., H. 6.

EDITORIAL.

ALBUMINURIA IN CHILDREN.

ALBUMINURIA in children is frequently overlooked, especially in private practice, in cases presenting none of the well-known characteristic symptoms usually accompanying the disease. The oversight depends upon a lack of frequent and systematic urinary examinations. It is now axiomatic that the younger the child the less dominant the "old time" symptoms. The indications often point to involvement of organs remote from the kidney centre, for instance, a simple high fever may be present, or vomiting, purging and collapse, or drowsiness and mild convulsive seizure, or simply anæmia.

The common cause of albuminuria in children is Bright's disease as a sequela of the acute infectious diseases so frequent in childhood. Again, Bright's disease may exist without any apparent cause and practically without indicating symptoms in children even as young as six months or less. In these cases when an urinary analysis is desired the urine can be collected by keeping the child on pieces of well-boiled linen on a rubber pad for some hours. By this method sufficient urine can be wrung out to give the desired chemical and microscopic tests. A sterilized silk sponge can be used in the same way. If retention is present, a small catheter will secure the fluid. Pus, blood or chyle, are rare causes of albumin in the urine of children. Morbid growths resulting in pressure will also give rise to presence of albumin. The most interesting phase of the question of albuminuria in children is the so-called functional albuminuria. By this is meant a renal albuminuria with absence of casts and all characteristic signs of Bright's disease or any other disease, the victim being to all intent and purpose in perfect health. The claim has been made that this condition is more frequent in boys than in girls. In cases of adolescence this seems to be established. It frequently accompanies the habit of masturbation. The amount of albumin present varies greatly; sometimes it is quite large. As a rule, it is limited, some in the morning, more at noon, and none at night, or, again, there may be none in the morning and quite marked at night; or, when the patient has been resting in bed, it may disappear altogether, remaining absent for some days after resuming the usual occupation of the day, and then from some apparently insufficient mental emotion or excitement a large quantity may reappear. The ingestion of food, or certain articles of food, like

eggs, seem to cause it to return. Time and again the chemical urinary analyses show an entire absence of albumin in the morning urine with a gradually increasing amount as the day advances, being highest in urine voided on retiring. For this condition no attributable cause can be determined, excepting the daily muscular activity of a child in contradistinction to the night's repose, which gives a morning urine free from albumin. If exhaustive microscopical examinations fail to give evidence of Bright's disease, such as tube-casts, renal epithelium, etc., then the cause of the albuminuria becomes speculative and unsatisfactory. To many authorities the diagnosis of functional albuminuria, or albuminuria of adolescence, is sufficient, while others fail to accept this comforting opinion and view with apprehension intermittent paroxysmal albuminuria, or the daily recurrence of a slight albuminuria as indicative of the existence of some unrecognized kidney lesion, or, at least, as the advance signal of the oncome of some form of Bright's disease. We hold with the latter and view skeptically the existence of a physiological albuminuria. The diagnosis of these masked conditions is extremely interesting and vexatious. We recently came in contact with a case in a girl, aged 13, who had an attack of diphtheria, with secondary glandular involvement. She convalesced nicely. On the fourteenth day the temperature rose suddenly to 103° F., with albumin in a scanty urine, amounting to nearly one-half the amount of urine examined in test-tube. The temperature fell rapidly, the albumin diminishing in pace with the fall of temperature; the latter remaining stationary at 99°, and the urine containing a trace of albumin for four weeks, no tube-casts ever being present. The following six weeks the urine was tested as follows: A morning, noon and night sample separately, every other day and a twenty-four hour sample every second day with negative results. The menstrual function was then established, and albumin appeared regularly for five days without casts. Then a period of six weeks passed without albumin, followed by a reappearance of albumin after a short period of nervous excitement, and so on. The question in this case arises: When was the albuminuria established? Was it the result of the diphtheria, or did it exist beforehand? In either event, there being no other symptoms but a high fever and a scanty urine at the time of the discovery of the albumin, the prognosis must be of the tentative or experimental type. The lesson to be drawn is the necessity of careful, exhaustive and persistently-repeated examinations of the urine for casts, in order to establish a diagnosis and prognosis in the by no means infrequent cases of albuminuria in children without symptoms.

GLEANINGS.

GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D., AND FRANK H. PRITCHARD, M.D.

THE FEVER OF PULMONARY TUBERCULOSIS AND ITS PROGNOSTIC IMPORTANCE.—Prof. A. Struempell, of Erlangen, calls attention to the fever of pulmonary tuberculosis and its importance prognostically. The fever of this affection is probably due to secondary inflammations. From this one may conclude as to the presence of complicating conditions and the probability of further extension. The measurements must be made morning, evening and afternoon; and only when a patient does not show a temperature above the normal for several days, can one be certain that he is not free from fever. Patients that remain for weeks, months or even years with undoubted pulmonary tuberculosis are by no means infrequent. Their disease is stationary. Cases with fever may be divided into several groups:

1. *Subfebrile Form.*—The morning temperature is normal, the afternoon and evening temperature high, yet never over 38.5. Such cases are never to be looked upon as stationary, but they belong to the slow and relatively benign forms.

2. *Intercurrent Hectic Form—Intermittent.*—The morning temperature is normal while the evening temperature is always elevated—over 38.5–40. In such cases one may assume a progressive course; the higher the evening temperature the more rapid the course.

3. *Remittent* and 4. *Continuous Forms.*—The remittent form with a morning temperature below the normal and a very high evening temperature is mostly observed in true florid phthisis. Continuous fever is remarked in miliary tuberculosis and sometimes in quite acute and suddenly beginning forms when physical examination gives no basis for diagnosis.

5. *Irregular Fever.*—This form is of ominous importance, for it not infrequently accompanies the last stage of tuberculosis. Low collapse temperatures are of especially grave importance. Complications may impinge upon these types.—*Wiener Medizinischer Presse*, No 15, 1893.

DANGERS OF MORPHINE IN ANGINA PECTORIS.—Prof. Huchard claims that the chief element of angina pectoris is not pain but threatening acute asystolia. Pseudo-angina pectoris, though very painful, are not fatal, while in the true disease death supervenes from syncope and without pain. Sometimes, instead of succumbing immediately the patients, in angina pectoris, suffer from very painful asphyctic symptoms which an injection of morphine will relieve, and thus mask the state, and be, at the same time, injurious. It is more rational to employ heart tonics at once, as caffeine, nitrate of amyl, etc.—*La Semaine Medicale*, No. 28, 1893.

THE ANTAGONISM BETWEEN RHEUMATISM AND TUBERCULOSIS.—It was an old dogma of Rokitsansky's that there was a very decided antagonism between pulmonary tuberculosis and valvular disease of the heart, and the point has often been discussed. Traube was inclined to admit the antagonism in the case of mitral disease only.

A year ago M. Potain published (*Gaz. Hebdom.* of September, 1891) a series of 55 cases of mitral stenosis among which there were 9 cases of tuberculosis. M. Lépine, of Lyons, thinks it very probable that in the cases of mitral regurgitation the congestion of the lungs leads to the killing of the tubercle bacilli by the pulmonary oedema. Dr. Fenwick's statistics, published in the pages of the *Practitioner*, xlvii., p. 339, 1891, of the results of 1560 post-mortem examinations of phthisical patients at the Brompton Hospital are important in this connection. He found true endocarditis recorded in 43 of these cases; in 30 of them it was of old standing, in 13, recent. Dr. Launois, of Lyons, relates an interesting case of a blacksmith, Claude C., who died in April, 1892, æt 39, of acute tuberculosis. He had four at

tacks of acute rheumatism; in 1870 with pericarditis, in 1875 with both endocarditis and pericarditis, in 1888 a severe attack without further cardiac disease, and again in November, 1891, when he first came into hospital. His heart was then hypertrophied but regular in action, and no murmur was heard at first, but the second was double and soon became rough. Along with this last attack there had been bronchial irritation and catarrh and this never completely left him, but by the beginning of April increased, with sharp fever (103° - 105°) but without any rheumatic pains, until he died after a week of delirium. The post-mortem examination showed that there was widespread and recent tuberculosis in the lungs and kidneys, but none in the pericardium or endocardium. Its point of origin could not be determined. There was a stiff irregular fringe to the aortic valves of old date, and marked retraction and incompetence of the mitral valves with long-standing adhesions of the pericardium.—*The Practitioner*.

REST IN CARDIAC DISEASE.—Dr. Lauder Brunton read a paper before the Brighton and Sussex Medico-Chirurgical Society on this subject. He sketched the condition of the circulation in a bad case of mitral disease, and showed that it closely approximated to the condition after death, where the arteries were empty and the veins overfull.

He demonstrated, by means of a partially-stopped syringe, that the mere loudness of a murmur did not necessarily mean great incompetence of the valve. In mitral disease there were three causes of regurgitation: thickening and contraction of the valves, dilatation of the auriculo-ventricular opening, and inco-ordinated action of the muscoli papillares. This last he had first observed in dogs poisoned by digitalis.

The second cause occurred as the result of over-strain in young and quickly growing persons, in chlorosis, in enfeebled hearts after acute disease, in fatty heart, and in the hypertrophied heart of aortic or chronic renal disease. Cases of dilatation from over-strain and in chlorotic girls were narrated.

These were treated by carefully-regulated exercise, or "comparative rest," as opposed to "absolute" rest.

Massage was a valuable adjunct to this treatment.

He thought the cases of weak heart action after influenza were due to a short and sharp febrile attack weakening the heart, but not lasting long enough to enfeeble the limb muscles and prevent active exercise. These cases, and some of fatty heart and early atheroma of the aorta, Dr. Brunton thought better treated by graduated exercise on Oertel's plan than by absolute rest. In many persons over middle age, before any signs of heart-failure appeared, a slight murmur over the aorta, just above the valves, might often be heard. Such cases improved under 10-grain doses of iodide of potash, with graduated exercise and attention to general hygiene. Passing on to consider absolute rest in advanced cases of mitral disease, Dr. Brunton again described the condition of the circulation, and showed that the albuminuria was due chiefly to the venous engorgement of the kidney, causing actual pressure upon the incompletely filled artery of the glomerulus and the tubules, thus causing a real mechanical impediment to the urinary secretion. This was still further increased by pressure on the ureter when the abdomen was distended with fluid. By tapping the abdomen or giving purges, and administering digitalis and other cardiac tonics, this impediment could be greatly overcome. When such means failed, absolute rest, which meant that the patient was not allowed to move a muscle for any purpose, and was kept in bed on a hair mattress, often did great good. In such cases Dr. Brunton advised a purely milk diet, which gave sufficient nourishment without overloading the system, and the lactose acted as a diuretic.

The milk diet was conjoined with daily massage. Dr. Brunton showed how massage emptied the lymph spaces around the muscles and increased the flow of blood to the tissues, thus aiding the elimination of waste products, and helping to bring fresh nourishment to the tissues. This process he likened to raking out the ashes of a fire, and adding more fuel to it.

Massage took the place of exercise, and helped to clear away œdema, and it also greatly relieved the sense of fidgetiness and unrest. By the combined use of absolute rest, cardiac tonics, milk diet, and massage, many patients, who had apparently only a few days to live, might be restored.—*British Medical Journal*, March 25th, 1893.

MASSAGE OF THE ABDOMEN BY MEANS OF A CANNON BALL.—Dr. Rose thinks this valuable aid to the treatment of chronic constipation has been overlooked and

neglected. To pay a skilled masseur is often beyond the means of our patients, and to remedy this defect Professor Jahli, of Berne, recommended the use of a 3-5-pound cannon ball, to be rolled around upon the patient's abdomen for from five to ten minutes a day, preferably in the morning before arising. Such a rolling ball massages equally and energetically, and its action may be increased by pressing with the hand on the ball. The rolling may be modified by dropping it from a few inches upon or rapping the abdomen. The patient should manipulate the entire abdomen, and especially the region of the colon and *sigmoid flexure*, in order to help mechanically the insufficient peristalsis. This method is simple, easy, and may be carried out by any one. The ball may be slightly warmed, or covered with woollen cloth. It is a good practice to keep it in bed a short time before using. A certain fixed time, preferably the morning before arising, should be chosen for this exercise. In several cases of dilatation of the stomach this method was of great service.—*Medicinische Neuigkeiten*, No. 7, 1893.

THE SCOTCH DOUCHES IN CHRONIC RHEUMATIC JOINT TROUBLES.—Schueller contributing on this subject says: "Of baths which have long played the chief rôle in the treatment of chronic joint troubles, the following are of greatest use: Steam baths, hot Sool-Moor baths, sand baths, and the Scotch douche. The latter consists of quickly alternating streams of hot and cold water, in a fine stream about the size of the finger, and of constantly varying pressure, coming from the same nozzle. In two simple cases, the sweating in woollen blankets and washing off afterward with cold water has been very effectual.

The Scotch douche effects not only the restoration of the thickened capsule, but also strengthens the muscular apparatus. It should always be used after the warm baths.

It seems to Schueller that the explanation of the fact that the different warm baths seem to be without permanent effect, and this often in cases where an improvement is possible, lies in their being applied too hot at the bath establishment. It takes a considerable time for the joints of a patient to resume their natural temperature after such applications. By these hot applications it is intended to induce a strong contraction in the vessels of the joint, to restore a healthy tone to the muscles, and thus to institute a powerful factor for the absorption of the pathological products.

But the sensibility of the patient to changes is greatly increased thereby. The result is that not only is a permanent result not attained, but on the first opportunity a new chill will be given and the old suffering commence anew. According to the author's idea of the physiological action of warm hydro-therapeutic applications in these diseases of the joints, each such application should be followed by a cooler even a cold application of water, either as an ablution or a douche. The Scotch douche again commends itself because it is so easily regulated as to temperature and can be borne by weak patients and above all, because it combines a distinct mechanical effect with the thermic effect upon the vessels and muscles. The end, which is in general sooner obtained by the baths, is a diminution of pain and increased ability of the joint. Real cures take place in such cases in which thickening of the capsule is present without formation of tufts, or in which the tufts are small and few in number. A firm thickened capsule, and even tufted formations of considerable extent can be entirely restored. If the tufts are large and numerous, then the baths have an ameliorating effect upon the pain, and restore in part the lost mobility. Many cases can be kept for years in an endurable condition by these means.—*Dietetic Gazette*, 1893.

A CASE OF HYSTERIC FEVER.—Prof. Henot relates the case of a woman of twenty-one years who entered the hospital for typhoid fever, which she alleged to have contracted from her husband, sister, or brother whom she had nursed through this disease. Three clinical anomalies in her case attracted attention: the sudden beginning of the disease, complete absence of prostration and the clearness and abundance of her urine, which had none of the appearance of the urine of fever. It was also learned that she had suffered formerly from hysteric attacks, though no stigmata were to be made out, nor had she any neurotic antecedents; yet her case was diagnosed as hysteric fever, though she had headache with vertigo, epistaxis, fever with the characteristic temperature of typhoid. The characteristic of this affection had been engraved upon her mind during the time that she cared for the three patients mentioned. Hysteric fever assumes various and capricious forms, and cases have been published where it has taken on the guise of febrile disease.—*La Semaine Medicale*, No. 28, 1893.

GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D.

THE MOST FREQUENT FOREIGN BODIES IN THE RECTUM.—Fest has found foreign bodies in the rectum to be a frequent cause of intertrigo, pruritis, erosions, fissures, etc. Long anal hairs are often included in the contracting sphincter and retracting rectum, at the close of defecation, producing tenesmus and the above-mentioned lesions. They should be completely removed. The undigested portions of sweet corn, grape, apple, tomato, or berry seeds are also the source of mischief at times. If the patient's stools are loose, these foreign bodies accumulate in the rectal folds, producing paraproctitis, abscess, and fistula. In one case of a young man who chewed toothpicks habitually, a fragment of a toothpick was the irritating substance. In another, suffering from supposed hæmorrhoids, an orange seed was the offending body. In a third, a child, a number of tomato-seeds produced the symptoms calling for interference. In children with tenesmus, the rectum should always be examined.—*Medizinische Neuigkeiten*.

PNEUMOTHORAX AND EMPYEMA FROM FRACTURE OF THE CLAVICLE.—Dèces records an unusual case: A young man who jumped out of a runaway carriage, sustained a fracture of the clavicle near its middle. There were no broken ribs or emphysema. Pneumothorax rapidly developed, and was followed later on by empyema. About a pint of reddish purulent fluid was evacuated.—*La Tribune Médicale*.

EXCISION OF THE RECTUM AND PART OF THE SIGMOID FLEXURE FOR MALIGNANT DISEASE.—Purcell (London) reports a case in which twelve inches of the lower bowel were successfully removed without a resection of the coccyx or a portion of the sacrum.

The anus was well dilated and the mucous membrane divided transversely about an inch above. The rectum was then separated from its attachment by blunt dissection and scissors for about five inches, when the peritonæum was opened anteriorly. By dividing the recto-sigmoid, meso-colon, and the remaining peritoneal attachments, the bowel was released and readily drawn down. The growth, a cylindroma or cylindroid carcinoma, was eight inches from the anus, and extended upward for three inches. Two inches beyond its upper limit the intestine was cut across, drawn down, and stitched to the mucous membrane inside the anus. A rubber drain was placed behind the bowel. The patient, at the time of the report, was making an uneventful recovery.

(The ease with which the bowel can be drawn down varies in different cases; this is probably largely due to the lax or tense condition of the meso-rectum.)

In a case operated a few days since, after dilatation of the anus, the rectum *rolled out* to such an extent that six inches were easily resected from the protruded bowel. The sphincters were saved, but the mucous membrane, from the skin margin upward, was removed, as the growth was low down. The bowel was then stitched to the skin without the slightest tension. The peritonæum was not opened, and the after-course was as simple as that of a hæmorrhoid excision.

In another case, however, after removing the coccyx and an oblique piece of the sacrum, a narrow carcinomatous stricture, without surrounding infiltration or attachments, and certainly not over five inches from the verge of the anus, was drawn into the wound with the greatest difficulty. It was not until the meso-rectum and the peritoneal attachments had been divided that the bowel came down easily. No harm resulted from opening the peritonæum, gauze being packed around the gut to produce adhesions.

In a third case, also operated recently, the growth involved the anus and extended upward some five inches. An incision was carried back to the coccyx and the rectum enucleated as far up as possible. Failing to reach the upper limit of the growth, the coccyx and a portion of the sacrum were removed. Even then the upper limit of the growth could not be reached, and it was not until the peritoneal attachments were divided that the intestine could be drawn and resected. The iodoform gauze pack again prevented peritoneal infection, and there was hardly any febrile reaction.

[In this connection, the suggestion of Maunsell (see *HAHNEMANNIAN MONTHLY*,

February, 1893, page 131) is worthy of consideration; it aims at loosening the attachments which prevent prolapse of the bowel, and at making the resection practically without opening the peritoneal cavity. In view of the success which attends opening this cavity from below, it is a question whether an abdominal section should be added to this already severe procedure.—EDS.]—*Lancet*.

TO PRESERVE STEEL INSTRUMENTS FROM RUST.—In order to preserve steel instruments from the destructive influence of rust, one may place a few pieces of the chloride of lime into a funnel, the end of which rests in a bottle to catch the liquefying salt. The chloride of calcium has a remarkable affinity for moisture and a few pieces will preserve a cabinet of instruments from rust, for several months.—*Le Bulletin Médical*, No. 8, 1893.

TREATMENT OF HYDROCELE.—The method followed in Billroth's clinic in ordinary cases consists of puncture, with the injection of a solution of two parts of iodine tincture and one of distilled water. Incision and excision are reserved for old cases with thickened walls or those in which the contents are purulent or bloody.—Gleich, in *Muenchener Medizinische Wochenschrift*.

TREATMENT OF HIP-JOINT DISEASE—Hausing states that the treatment of tubercular coxitis in Billroth's clinic is essentially conservative, the plaster-of-Paris breeches and extension in the recumbent position being used with very satisfactory results. Abscesses are treated by puncture and injection of a solution of iodoform. Resection is practiced only in cases of profuse suppuration, steady loss of strength, rise of temperature, and pain which is not relieved by either extension or the plaster-of-Paris breeches.—*Muenchener Medizinische Wochenschrift*.

PAINFUL VARICOCELE.—Gillis announces the remarkable (!) discovery that hamamelis internally will relieve varicocele. He gives ten drops in five ounces of distilled water, the whole to be taken in tablespoonful doses during the course of twenty-four hours. With this, cool lotions are applied to the scrotum night and morning and a suspensory is worn.—*La Semaine Médicale*.

[This is as wonderful a discovery as that recently published by an English writer, i.e., that dilatation of the anus is useful in the respiratory difficulties of a spasmodic character during etherization.—EDS.]

PERITONEAL ADHESIONS AFTER LAPAROTOMY AS A CAUSE OF DIGESTIVE DISTURBANCES.—Jahreis publishes the case of a woman who had been operated upon for a double pyo-salpinx following a post-partum intra-uterine injection. Two months after the operation she was seized with dysuria and strangury as well as with grave intestinal symptoms: vomiting, violent colics, which were continual and kept her bent double nearly all the time. She became a morphiomaniac. Her condition was diagnosed as due to peritoneal adhesions from the former laparotomy. An incision was made at the site of the old cicatrix, and the adhesions, which were very thick above and fine below, were separated. The symptoms disappeared entirely.—*La Tribune Médicale*.

RADICAL TREATMENT OF UMBILICAL HERNIA.—Condaman (Lyons) proposes a radical treatment of umbilical hernia in adults that is quite certain not to be followed by a recurrence. The entire umbilicus is resected circularly, the sheath of the rectus opened on both sides, and, first, the posterior layer of the sheath of this muscle, and then the anterior united by a line of sutures, while a third joins the skin. Thus all points of departure for a recurrence are removed.—*Muenchener Medizinische Wochenschrift*.

PURULENT ARTHRITIS CURED BY AN INJECTION OF A SOLUTION OF CORROSIVE SUBLIMATE.—Rendu reports the case of a woman who had suffered for fourteen days from an inflammation of the left knee-joint accompanied by violent general symptoms. The articulation was immobilized in a splint for forty-eight hours, when, the symptoms growing worse, a puncture of the joint was made, and eight ounces of a greenish pus evacuated. At the same time three syringefuls of a solution of corrosive sublimate (4 : 1000) were injected into the articulation. The joint was then immobilized and wrapped in cotton. The patient improved at once. In twenty-four hours her temperature was normal, but in ten days the effusion reformed. Puncture was repeated, and a serous fluid withdrawn. Compression was made with a cotton dressing in a hollow splint. Three weeks later she was discharged as cured, with only a slight stiffness of the joint. The disease was discovered to be of gonorrhœal origin.—*Muenchener Medizinische Wochenschrift*.

GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D. AND J. NICHOLAS MITCHELL, M.D.

RELATION OF SURGERY TO KIDNEY DISEASE.—Dr. Charles W. Purdy spoke upon this subject before the Gynæcological Society of Chicago. He related the following case: The patient was the daughter of a physician. The morning before the operation it was discovered that the urine contained albumin, and the case was referred to Dr. Purdy for an opinion as to the condition of the kidneys and the advisability of operation. After a careful examination he found interstitial nephritis moderately well advanced. The capacity of the kidneys was reduced 30 or 35 per cent. if not more. The patient would die in a short time if not operated upon. Dr. Purdy told the patient and her friends that he believed that by preparation of a month, the operation might be undertaken. The risk was placed at 20 per cent. The patient being anxious for the operation, was sent home and directed to live upon a strictly non-nitrogenous diet for a month—no meat whatever,—milk, gruel, fruit and farinaceous food. Ten days before operation she was put upon a diuretic, the acetate of potassium, and the quantity of urine was run up to 100 ounces per day and kept there till a few days before the operation. She then went to the hospital and Dr. Fenger removed a 40-pound myocystoma. After the operation the patient never took a dose of medicine. She made a rapid recovery and is to-day about her usual duties. In diabetes, of course, we should not operate; but in early cases of interstitial nephritis, where there is a normal quantity of urine which does not show a reduced specific gravity under 1.010 to 1.014, and where the amount of urea does not sink lower than six or seven grains to the ounce operation can, I believe, be performed with comparatively slight risk. Cases of interstitial nephritis are risky ones to surgeons in general, because they are very apt to escape detection before an operation, as the chief reliance has always been the detection of albumin in the urine.

The doctor has published 170 cases where the autopsy has shown contracted kidneys and no albumin in the urine during life. If the kidneys are overtaxed by a highly nitrogenous diet as a man passes 40, they begin to tire and contract, and we have interstitial nephritis. They are usually people who eat meat three times a day. Nine-tenths of these patients have an enlarged left ventricle of the heart; but before we find any evidence of such enlargement we will find a very sharp accentuation of the second sound of the heart; the radial pulse is very hard, very tense, and very full. If a patient beyond forty years of age rises at night to pass urine more than once, or even once habitually, and there is nothing to account for it in the way of irritable bladder, stricture or cystitis, it is one of the most constant symptoms of interstitial nephritis, although it is not always present. Take the 24 hours' quantity to obtain the specific gravity. Place the patient upon an ordinary mixed diet, and if the specific gravity of the urine is 1.010 to 1.014, go further and examine for urea. If we find, instead of ten grains of urea to the ounce, seven, eight or six, the disease is advanced, and we have something tangible to show that the kidneys are incompetent; we have a lowered specific gravity and a lessened quantity of urea; the patient rising at night; we have an accented second sound of the heart, and we have interstitial nephritis in such cases whether there is albuminuria or not. It is very difficult to find hyaline casts by ordinary methods in interstitial nephritis. If the urine is concentrated you may find them. One of the least difficult methods is this: Take a wine glass holding about four ounces, fill that with urine and add a half-drachm of saturated solution of resorcin, cover the glass and let it stand for one or two days. After a day or two take the bottom drops from the glass and place them under the microscope. Focus carefully, having the field rather dark, and if there are casts their shadow will be visible, and focusing with a fine adjustment, the cast themselves. What has been said has been limited entirely to interstitial nephritis, chronic Bright's disease, or contracted granular kidney. No investigation has been made with reference to operations in cases of chronic parenchymatous nephritis, but I see no reason why these cases, if unaccompanied by dropsy, may not be operated upon in selected cases. Additional remarks were made by Dr. F. B. Robinson. He said that the worst kidney trouble followed cutting off of the hypogastric and ovarian plexus. This is so because the kidney, Fallopian tube, uterus, ovary, and vagina arise out of the Wolffian body,

and hence are physiologically and anatomically connected. The standard of test for operation on any woman in regard to the kidney is the amount of urea she has in her urine. An ordinary-sized woman should not be operated upon unless she has at least two hundred and fifty grains of urea a day. She should have at least seven grains of urea to the ounce of urine. Albumin is not reliable as a standard. —*American Journal of Obstetrics*, 1893.

CARE OF THE BOWELS BEFORE OPERATION.—Dr. Martin uses the mercurials as nothing else so well accomplishes his purpose. If the stools are burnt like black walnut, or if they are very light colored like manilla paper, the condition of the bowels is not satisfactory. When you get a stool that is yellow or green in color, such as you see in the infant nursing its mother, there will be little or no trouble with intestinal gas or fulness of the abdomen, after operation; this the mercurials will give quickly and thoroughly. The more prolonged an operation, the greater the danger from the ether, from disturbances of the nutrition every way. If the operation can be short ether will rarely be dangerous—an argument in favor of celerity.—*American Journal of Obstetrics*, February, 1893.

ANTISEPTIC TREATMENT OF CHRONIC METRITIS.—In an article on this subject Dr. W. A. Briggs says, that creosote is quite the equal of carbolic acid as a solvent for iodine, and that camphor-creosote is greatly superior. He has used both iodized creosote and iodized camphor-creosote. The latter is prepared as follows:

R.	Camphoræ,	.	.	.	.	.	.	.	16 grammes.
	Creosote fagi eylvat,	.	.	.	.	.	.	.	6 c.c.,—M.
S.	et adde iodi resub,	.	.	.	.	.	.	.	7 grammes.

The advantages of this combination are: (a) It does not coagulate albumin; being thick and oily, and having no affinity for water, it does not come in such rapid contact with the mucous surface as the tincture of iodine does, hence is not so likely to produce severe pain; (c) It contains by far the largest ratio of iodine of any liquid preparation with which he is acquainted, roughly estimated at about 30 per cent. by weight, and hence can be used in correspondingly smaller quantity and with marked immunity from uterine colic. After the usual antiseptic precautions, and the intra-uterine injection of from five to ten minims of iodized camphor-creosote, introduce into the uterus a platinum electrode, whose active surface corresponds in length with the uterine cavity, and constitutes the positive side of the utero-abdominal current, varying from five to twenty milliamperes. The electrode should be covered with absorbent cotton, saturated with iodized camphor-creosote and made to sweep the mucosa in its entire extent. The sitting should last from five to ten minutes, and be repeated every second or fourth day.—*Annals of Gynecology and Pediatrics*, 1893.

INTESTINAL PARALYSIS FOLLOWING LAPAROTOMY.—Eugene Boise, M.D., relates the following case of intestinal paralysis following laparotomy. After the operation the bowels gradually became distended with gas, and the stomach refused to be quieted. Sulphate of magnesia was given in repeated doses, but with no effect. Enemata were then resorted to, turpentine and castor-oil, ox gall, large quantities of water administered through a long tube, concentrated solution of salt, etc., but with no result. There was constant regurgitation from the stomach, with some abdominal pain and increasing tympanitis. Death from intestinal paralysis in twenty-four hours was predicted. All active measures were stopped, and one-quarter grain morphine administered hypodermically. Cessation of pain and vomiting followed and after several hours, the administration of another enema was followed by copious, free and offensive discharges. From that time the patient recovered and is now enjoying good health.

Irritation of the sympathetic plexuses in the mesentery, as in other parts of the body, causes contraction of the arteries with consequent diminution of oxygen and relative excess of venous blood. By this, peristalsis, more or less violent is excited. Continued or too violent irritation of these nerves soon exhausts them, the muscular tone of the intestine is gone and it becomes distended with gas. This paralysis soon passes away in the subsidence of the irritation. Another explanation is that over-excitation of the sympathetic nerves supplying the intestine may cause intestinal paralysis.—*The New York Journal of Gynecology and Obstetrics*, February, 1893.

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

THE EMPLOYMENT OF OIL OF TAMAQUARY IN CORNEAL AFFECTIONS.—M. Mello Vianna has studied in detail the composition, the pharmacology, and the physiological properties of the oil of tamaquary, derived from a tree in the Amazon province, belonging to the family of Ternstroemias. He recalls the fact that this substance was first used in ophthalmology by Moura, Brazil, in 1883. Since then it has been used experimentally in De Wecker's clinic. Vianna, resuming this study, has used tamaquary oil in all affections of the cornea, and, without going into the details of the forms of keratitis thus treated, it may be said that his results are worthy of attention of lovers of new therapeutic proceedings. According to him, all kinds of keratitis, except, perhaps, interstitial keratitis, are advantageously affected by this medicament, but its action is especially efficacious in phlyctenular keratitis. Out of a series of seventy-eight cases of this affection, the author had seventy-eight recoveries. The following is the formula which he uses:

White vaseline,	. . . . .	10 grammes.
Tamaquary oil,	. . . . .	40 grammes.

A few particles of this salve are applied directly to the cornea, and then the upper lid is rubbed slightly over the surface. The local treatment must never cause general medication to be neglected.—*The Therapeutic Gazette*, April 15, 1893.

THE PATHOLOGY OF OZÆNA.—Abel (*Centrbl. f. Bakt.*, Band xiii, Nos. 5 and 6) has found, in sixteen cases of ozæna, a bacillus with characteristic features. It is present, with many other organisms, in the muco-pus lying beneath the scabs which cover the nasal mucous membrane. In other varieties the author has not found this organism. The rods are short, plump, sometimes enclosed in a well-marked capsule, and often arranged in twos or in chains. He states the results of bacteriological investigations into the subject of ozæna as follows: In all cases examined by himself, and in most of those examined by others, a bacillus with distinctive features, which is not present in any other disease, has been found. This may be regarded as the cause of ozæna. Probably the specific organism has nothing to do with the production of the well-known fœtor; the odors given off by cultures justifies this supposition. The secretion poured out by the diseased mucous membrane which harbors the parasite is an excellent culture medium for various saprophytes capable of decomposing albuminous substances; and to their action the peculiar odor of ozæna is to be ascribed. When the ozæna bacillus is absent, as in simple chronic inflammation of the nasal mucous membrane, the specific secretion is not furnished; hence, there is no decomposition, and consequently no fœtor.

THE EXTRACTION OF FOREIGN BODIES IN THE EXTERNAL AUDITORY CANAL BY THE AGGLUTINATIVE METHOD.—In the ordinary methods employed for its removal a foreign body is pushed quite to the bottom of the canal and against the tympanum. The difficulties in the way of extraction are often almost insurmountable.

Some Swiss practitioners have employed alum as an agglutinative substance for the extraction of foreign bodies. But this agglutinative agent may produce dangerous burns. On account of this possibility, solidified Venice turpentine has been offered as a substitute. A slightly heated nail is applied to the turpentine. A drop of the melted turpentine is placed on the foreign body by means of a match, which is left in position for an instant and then withdrawn by the fingers or pincers.

This same process is applicable to the removal of foreign bodies in the nose. When such a body is firmly fixed, the match must be left in place for at least a minute.—*Merck's Bulletin*.

SOME CASES OF SYPHILIS OF THE PHARYNX AND LARYNX.—The rapid cure of these grave cases justifies their publication. In two cases the difficulty of respiration was such that tracheotomy became necessary. The publications of Lukasevitz persuaded the author to try intra-muscular injections of a five-per-cent. sublimate solution, using a syringe full (hypodermic) once a week, in the buttocks, each side alternately. In two cases the injections performed a rapid cure. There was neither stomatitis, salivation, nor severe pain or infiltration.—*Rev. Gen. de Med.*

MONTHLY RETROSPECT OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D., AND FRANK H. PRITCHARD, M.D.

GRAPHITES IN HERPES ZOSTER.—Dr. George Royal reports the case of a woman, aged 23 years, in the third month of gestation, who presented the following symptoms: Four days before coming under treatment she experienced severe pain, beginning a little to the left and just below the umbilicus, and extending to the left hip. The pain came on in paroxysms and left a soreness. The next day there appeared little pimples over the same territory, which itched terribly, and, after being scratched, smarted much. There was also a little moisture about the eruption. The itching and smarting were worse from warmth, and so intense that the patient had not slept for two nights. Objective symptoms: Small ulcers and vesicles from the umbilicus to the spine of the ileum. The vesicles were filled with a watery secretion. About midway a branch of the eruption dipped down to the pubes. This had appeared only that morning. There were little red pimples, each tipped with a little white watery secretion. Graphites, sixth attenuation, was prescribed. All the symptoms were allayed very soon, and the case cleared up completely in two weeks.—*The Medical Century*, February, 1893.

CAULOPHYLLUM IN DISEASES OF WOMEN.—There are certain conditions in which caulophyllum should become a very popular remedy. They are:

1. Where labor pains are weak: (a) when they do not press downwards but pass off with a shivering; (b) where the pains have disappeared from exhaustion; (c) when the pains are spasmodic and too severe.

2. In spasmodic after-pains it has been found indispensable.

3. It is most useful in the false annoying pains a few weeks previous to labor; in fact, for any spasmodic pains of the uterus or in the pelvis occurring at any time from cold, rheumatism, suppression of the menses, or lochia.

4. It is a powerful agent for the prevention of miscarriage or premature labor, always providing the pains are of a spasmodic character.—Dr. H. C. Aldrich in the *Medical Century*, February, 1893.

OSMIUM FOR PAROXYSMAL COUGH.—Dr. George M. Ockford reports the case of a man, æt. 50, who had severe cough proceeding from the larynx. The cough was in severe paroxysms, and attended with much soreness and rawness in the throat and chest. Causticum failed, but osmium 4 gave prompt relief and cured the trouble.—*North American Journal of Homœopathy*, March, 1893.

A CHARACTERISTIC OF ASAFOETIDA.—A pronounced characteristic of asafœtida not generally known, is the following: "A sensation of emptiness and weakness, with distension and throbbing in the stomach and in the abdomen together, attended with gurgling and rolling of wind, which is hardly ever passed downwards, but escapes upwards with loud and difficult eructation, giving relief." My attention to this symptom was riveted some fifteen years or so ago in a case in which *argentum nitricum* had failed, but this remedy quickly cured. I would say, also, that obstinate constipation is very often associated with the aforesaid condition.—Dr. A. C. Clifton, in the *Monthly Homœopathic Review*, April, 1893.

HEART CHARACTERISTIC OF AURUM METALLICUM.—"Sensation as if the heart stopped beating for two or three seconds, immediately followed by a tumultuous rebound lasting for a few minutes, attended with sinking at the epigastrium, and with great fear of death." This complex of symptoms should be compared with one

under *digitalis*, viz., "fear that the heart will cease beating if the patient moves," the reverse of *gelsemium*, viz., "fear that the heart will quite stop unless the patient moves, attended with intermittent beat, coming on especially when lying on the left side." These symptoms are all largely clinical symptoms, which I have repeatedly verified, and for this reason I consider them characteristic; but, in order to differentiate them more clearly, it should be noted that the pulse of *digitalis* and of *gelsemium* is slower than the pulse of *aurum*.—*Ibid*.

THE TONGUE AND PULSE SYMPTOMS OF BAPTISIA.—The *baptisia* tongue is dry and brown in the centre, with dry, glistening edges, some amount of cracking of the surface and soreness, together with fœtor of the mouth; the pulse rather slow, and is very compressible, all indicating, and especially with other "characteristics," a low condition. The *veratrum viride* tongue is dry and red in the centre, with hot and scalded sensation extending to the throat, and the pulse is thin, hard, and wiry, and very quick, all of which symptoms point to an acute febrile condition, inflammation of some organ or tissue, and I have found this remedy of especial value in pneumonia and peritonitis. Apart from pulse symptoms, the tongue of *argentum nitricum*, of *antimonium tart.*, and of *phosphoric acid*, is in each case very similar in character to what I have named in relation to *baptisia*, but of course there are other characteristics which serve to differentiate the several medicines for therapeutic purposes.—*Ibid*.

GASTRIC SYMPTOMS OF BARYTA CARB.—Pain and heavy weight in the stomach immediately after a meal, with tenderness over the epigastrium, and the pains are worse by movement, often accompanied with difficulty and pains in swallowing food as if the food was arrested in the œsophagus; this complex symptom under the nomenclature of dyspepsia and gastralgia, occurring more especially to young men who have masturbated, and who suffer from seminal emissions, together with cardiac irritability and palpitation, which is worse when lying on the left side.—*Ibid*.

CHARACTERISTIC OF CALCAREA CARB.—Icy coldness inside and outside of the head, with perspiration on the scalp. Although this symptom is very pronounced, and when it occurs in any case will often lead to this medicine being prescribed, I have, nevertheless, seen the benefit several times of comparing *chelidonium* with it, and which has led me to select the latter medicine with advantage to the patient, for *chelidonium* presents "coldness in the occiput, rising from the nape." Silica, moreover, demands comparison, inasmuch as it presents "cold feeling from the nape of the neck to the crown of the head, with profuse perspiration of the scalp.—*Ibid*.

CICUTA VIROSA IN TRISMUS AND RHEUMATIC TETANUS.—Dr. W. Heyberger was called to a peasant, who while plowing, had worked himself into a sweat and then was wet through, by a shower and forced to walk home, in an icy wind. He complained of headache, difficulty in swallowing, pain in the back of the neck, extending to the lumbar region, with pain and tension in the throat muscles. Speech difficult. For three days he had felt unwell after the wetting and had kept his bed, sweating profusely. Various remedies were given, without relief. In two days his whole neck was hard, tense and swollen, from the lower jaw to the clavicle. Under *bry.*, 3x and *kali carb.*, 3x, this decreased. Pulse 80, constipation and reddish urine. No disturbance of the sensorium, though his head was confused. Sudden attacks of opisthotonos set in during lying, sitting, swallowing, standing, or attempting to speak. His head was drawn back by the contracted nuchal muscles which would relax on helping the patient up again. No loss of consciousness and able to speak after the attack. Unable but slightly to open his mouth. It was impossible for him to stand as it would bring on an attack and throw him down. Girdle sensations around the chest. *Cicuta vir.*, 3x, was given on account of the "sudden attacks," one dose every four hours. The spasms lost their violence, were less frequent and gradually the trismus disappeared. As he then complained of a wooden and numb sensation in his tongue, hands, larynx, nuchal muscles and feet, he received *kali iodat.*, 2x, and *cicuta vir.*, 3x, which so relieved him that he was able to return to his work after twenty-one days of treatment.—*Allgemeine Hom. Zeitung*, Nos. 13-14, 1893.

SILICA.—Dr. Windelband regards silica, together with *natrum mur.* and *calc. carb.*, as one of the most wonderful remedies. It is a similimum of tuberculosis, especially when it attacks the bones and joints. He has cured a series of articular

and osteal tuberculosis with this drug. *Calcium fluoricum*, 3, he now and then employs, on account of the scrofulo-tuberculous habitus in children, with swollen lymphatic glands, in every place where they are usually found. Silica is also here a very important remedy in this condition. The first case cited is that of three children, of 8, 11, and 13 years, respectively, who had lost the first and after the second phalanges of the fingers and toes, from progressive tuberculous process, appearing as a slowly advancing osseous ulcer of the end of the phalanx, with purulent secretion and club-shaped enlargement of the next joint and the whole finger. They had been under treatment for years. Silica, 3 trit., healed the ulcers, improved their general appearance, so that they are fresh and healthy instead of cachectic and miserable. The fluoride of calcium was also given, intercurrently. A second case was a large white swelling of the knee-joint, with high fever, cachexia, and enlarged glands, in a one and a half year old child, who received silica, with *chininum arsenicosum*, every two hours, intercurrently—one and a half grains, of the third centesimal trituration. In three to four weeks the hectic fever disappeared, the general condition greatly improved, and though an ulcer formed, with suppuration, cicatrization, with complete decrease in size of swelling of the epiphyses, followed. Calc. carb., 4, and sulphur were given for the fever and scrofulo-tuberculous habitus. After a year the child has a serviceable limb, which is nearly straight. He has seen several such cases cured by silica in the Berlin Homœopathic Polyclinic. Silica was of great service in a case of exophthalmos from growth of a sharp and pointed osseous protuberance from the bone of the orbital cavity, which pushed the right eye out so that it presented a terrible appearance. Vision was threatened from the consecutive inflammation of the cornea and conjunctiva; the eyelids no longer covered the eyeball. Enucleation had been proposed as the only measure to save the other eye. Sil. 3, was given, and in a few weeks amelioration followed; in fifteen months a complete restoration to the normal occurred. In felon and all hyperplastic granulating processes, especially of the bones, silica is the remedy. Psoas abscesses, cold abscesses, caries of the vertebræ and bones, glandular abscesses, and fistulæ and osseous ulcers of a tuberculous origin are cited as cured by this deeply acting remedy. He regards the present provings as incomplete, and will soon present a report of some made with material doses.—*Zeitschrift des Berliner Vereines Hom-Aerzte*, Bd. xii., Hft. i.

TREATMENT OF VARICOSE VEINS.—Dr. P. Jousset does not consider varicose veins as simple dilatations of the vessels but rather as partial and irregular hypertrophies of the venous system, with increase of volume, in both calibre and length. Deeply seated varices may precede the external ones, the malleoli being tensely painful, with relief on elevating the limb, œdema, pigmented plaques, bluish spots on the skin, disseminated here and there, are the accessory signs of the deep variety. A vein may rupture: there is a very intense pain, accompanied by immediate and considerable swelling and loss of power in the limb which is followed by the appearance of ecchymoses, after a few days. The majority recover, with rest, in the horizontal position, after one or two months. Others perish from embolism and phlebitis. Other possible accidental complications are: external rupture of a varix and varicose ulcers. External rupture of a varicose vein is rare. It is usually associated with a profuse hæmorrhage which yields to compression. Varicose ulcers are a frequent complication.

A rubber stocking prevents the further development of the disease and possible accidents. Pulsatilla and hamamelis are the two principal remedies of use in this affection. They diminish and control the pain. They will not cause the varices to disappear but merely control the painfulness. Arsenic and lycopodium are also employed in such cases, without any positive indications being known. Varicose ulcers require the horizontal position and the external and internal use of *clematis vitalba*. This remedy is used by beggars to produce an artificial ulcer on the legs (Nufiez). The writer has confirmed its efficacy many times, in the third trituration, two doses twice a day. At the same time one may employ a dressing of the glycerole or a salve of vaseline made with one-twentieth of the first trituration.—*L'Art Médical*, No. 3, 1893.

FOUR CASES OF POISONING BY HYOSCYAMUS AND ONE BY ATROPINE.—Dr. Rudolf observed four cases of poisoning, by the seeds of *hyoscyamus niger*, in young children. The first was that of a boy of 11 years who was brought to the hospital by his father. He sat upon a bench and had to be held while he threw his

arms and legs about so that his father was forced to hold him. His face was reddened, lips dry, pupils dilated to their utmost; if uncontrolled he would throw his limbs about, roll here and there, try to arise and then fall back and often cry aloud. Pulse small, 106. Respiration 26. Temp., 38.3 C. An injection of morphine induced sleep, after the stomach had been washed out. In the meantime the father had brought the other two children. Emil, 5 years, who was so excited that he had to be carried, and Otto, 9 years old, walked to the hospital. Emil spoke continually disconnected words, in a hoarse bass voice, whistled now and then, shook his head, pressed it backwards, here and there and reached out and picked in the air. Lips dry. The skin of the thorax and especially of the nates, presented a diffuse and scarlatinous exanthem. Face red and the pupils extremely dilated. Temp., 37.2 C.; pulse, 102, and the respiration more frequent than normal. A morphine injection produced rest. Otto presented a reddened face, hoarseness, widely dilated pupils which did not react to light. He was apathetic and still. He had swallowed 20 seed-capsules, the most of the three. Pulse, 100; temp., 37.3 C.; respiration normal. Mrs. L. brought her son, a 7-year-old boy who had been together with these same children, and who had eaten only one capsule. His mouth was dry, voice hoarse and lips dry, cheeks slightly reddened. Sensorium uninvolved. Neither sleepy nor excited. Pulse, 76; temperature, 36.6 C.; respiration normal. The children had gone away at 9.30 in the morning, and returned at 1.30 in the afternoon. Emil said that his teeth ached and that he was thirsty. Walter had seated himself at the table, eaten a spoonful of soup, jumped up and run away saying, "I want to find my father—there runs some mice,"—struck about him, and tore his coat. In the evening Otto became restless, wanted to leave his bed gesticulated wildly and spoke in a confused manner. At 11 o'clock Otto was picking things from the wall, as in delirium tremens, threw everything out of bed, whistled and said: "There stands a policeman—There comes my father—86 and 50 are 36, Emil, come carry my books—There go the coaches." Several injections of morphine brought about a calm, with delirium. Emil was restless the whole night. He awakened at nine, bored his head into the pillows, jumped up suddenly, stared at a certain spot, twisted his head, drummed with his fingers, cried, whistled through his teeth and said: "Some one died down stairs—Mamma, you gave me too little meat—There are torches, etc." Morphine was again injected and he fell asleep, at seven in the morning. The pupils were contracted during sleep, yet on awakening they would dilate to their utmost. The exanthem had disappeared. At 11 in the morning he awakened and with his mind completely clear. Walter, the next morning, was awake in his right mind and said, laughingly, that he had eaten 21 capsules of jimson weed. The fourth child was still somewhat hoarse, his pupils moderately dilated. Otto was still restless, but after a warm bath, with cold affusions to the head, he awakened, the same afternoon, in good health. Two days after they were discharged, with dilated pupils. That night they all slept well.

Four days after a policeman brought to the hospital a woman, 30 years of age, whom he had found wandering about, aimlessly, at the depot. She could neither give her name nor tell where she wanted to go; spoke nonsense, with a far away and lifeless voice. She swayed back and forth. Now she would seat herself and then arise from the chair. On harshly speaking to her her attention was fixed, for the time, and so her name, occupation, age, etc., obtained. She reached out for the physician's watch chain and the sabre of the policeman. The pupils were found to be extremely dilated and without reaction. Corneal opacities on both eyes. Her lips were dry, and covered with a dried whitish-yellow crust, tongue coated white; face reddened; pulse, small, 132; respiration, 32; sensibility not disturbed; patellar reflex somewhat exaggerated. Stools and urine passed involuntarily. No fever. A letter was found in her pocket in which she said that she was about to commit suicide, by taking a solution of atropine that had been prescribed for her eye affection. After a cold bath she was less restless but talked to herself in a low and feeble voice; her arms twitched convulsively. Her stomach was washed out and a greenish fluid, containing atropine, obtained. Morphine was injected, and as she was yet restless she was placed in a solitary cell. Her mistress came and said that at half past six in the evening, she impressed her as if she was intoxicated. A 2½-drachm bottle was found containing a few drops of atropine solution. In the evening she was yet confused and was given coffee and wine. A bath was again prescribed when she struck wildly about her. Morphine. That night she slept quietly. The next morning her mind was clear, only vertigo and a confused feeling in her head remaining. She related that she had dropped 20 drops of the

solution of atropine into her eyes and drank the rest, laid back upon her pillow awaiting death. After a quarter of an hour which seemed insufferably long she fell asleep. From then on she remembered nothing.

Comparison of Poisoning by the Two Drugs.—Both have the cardinal symptoms: Dryness of the mucous membrane of the mouth, lips, pharynx; reddened face, dilated pupils, and psychic disturbances.

With hyoscyamus, the excitement is associated with hallucinations. Inclination to sleepiness, a characteristic of hyoscyamus according to Schroff, was present in but one case. During this hyoscyamus sleep the pupil became contracted in one of the children only. Gnauck designates this as also characteristic of the drug. In the others it acted like atropine, i.e., it was dilated. There appears to be an antagonism between morphine and hyoscyamus and belladonna, but the dose must not be too small. [Unverricht, of Dorpat, in the *Fortschritte der Medicin*, 1890, relates several cases of poisoning by opium where a dose of atropine was given, as an antidote, that exceeded the lethal limit by twenty-four times, and yet the patient recovered.—Eds.]. Dr. Crowell claims, with hyoscyamus 6, to have made a marked improvement, in a case of morbid and groundless jealousy, in a married musician.—*Archiv fuer Homœopathie*, No. 2, 1893.

TREATMENT OF EXANTHEMATIC DERMATITIS.—Dr. J. P. Tessler has made a study of the drugs acting upon the skin.

I.—ROSEOLA.—Aconite or copaiva.

II.—SCARLATINOID ERUPTIONS.

Benzoic acid and the *benzoate of soda* give rise to an erythema with desquamation.

Boric acid and the *borate of soda* sometimes cause very extensive erythema.

Salicylic acid and the *salicylate of soda* produce erythematous eruptions, sometimes very intense and prolonged, simulating desquamative scarlatiniform erythema.

Antipyrine gives rise to an erythema in plaques, small irregular and slightly elevated, either discrete or confluent, in large patches, followed by desquamation.

Belladonna and *atropine* are followed by especially erythematous eruptions, of a brilliant red color, scarlatiniform and pruriginous.

Chloral has an erythematous eruption with a preference for the face and the extensor folds of the articulations. The eruption is especially scarlatiniform.

Copaiva provokes an erythematous eruption upon the wrists, hands, forearms, ankles, knees, chest and abdomen.

Iodide of Potash is associated with erythematous eruptions that are either diffuse or in irregular plaques upon the face, arms, or chest; these are rarely generalized.

Opium and *morphine* give rise to erythematous eruptions, more or less intense, which are scarlatiniform, desquamative and itching.

Sulphate of quinine produces a simple erythema which is scarlatiniform, rubreoliform or erysipelatoid.

POLYMORPHUS ERYTHEMA.

The treatment of this disease, erythema nodosum, is more advanced. The writer places chief reliance upon the *sulphate of quinine* in the lower attenuations. The *iodide of potash* is also recommended, with good reason, by Villemin as marvellously specific.

TRAUMATIC ERYTHEMA.

Remove the cause and apply compresses wet with arnica or chloral water, starch powder, lyconodium or camphorated talc.

PURPURA.

The clinical distinctions of simple peliosis, scurvy, Werhoff's disease, are useless in treatment. The remedy that will cure the most simple form will also cure the most severe, provided that the similimum be well chosen. Bryonia has petechiæ, fungous gingivitis, vomiting of blood and metrorrhagia. Though it was often prescribed with success, the present generation seemed to have neglected it. Arsenic, hamamelis, lachesis, phosphorus, secale and vipera are the most important remedies. Then comes ferrum perchloridum, ipecacuan, ledum and quinine.

Arsenicum.—Petechiæ, eruption of black pustules, pustules filled with blood. Violent epistaxis, bleeding and swelling of the lips. Vomiting of bloody matters; bloody urine. The periods are too frequent and profuse. Cough with expectoration of bloody mucus. Swelling of the arms with blackish pustules.

Hamamelis.—The pathogenesis of this drug is faulty, but from its empiric use it seems to be a precious remedy.

Lachesia.—Hæmorrhages and extravasation of blood into various organs. Ecchymoses. Easy and profuse bleeding from wounds and ulcers. Blood oozes from the pores of the skin; profuse epistaxis. Loosening and insecurity of the teeth; painful swelling of the gums. Vomiting of pure blood or of bloody mucus. Evacuation of pitchy stools, bloody stools or of pure blood. Urine turbid, brown or red. Sanguinous sputa. Extravasation of blood into the lungs.

Phosphorus.—Bleeding from various organs, from small wounds; epistaxis; the gums bleed. Painful sensitiveness and inflammation of the gums; they separate from the teeth and bleed easily. Vomiting of blood. Bloody diarrhoea. Hæmaturia. Menses too profuse and early. Cough with expectoration of blood. Spots like petechiæ upon the legs.

Serale—Petechiæ. Black or gangrenous pustules. Bloody vesicles, passing on to gangrene, upon the extremities. Epistaxis. Bloody mucus and froth in the mouth. Hæmaturia. Metrorrhagia of blackish blood. Swelling of the hands with black pustules. Swelling of the feet with black pustules.

VI—VASCULAR AND PIGMENTED SPOTS.

Their treatment is more surgical than medical. In pigmented plaques arsenic and silica, in whitish or colorless spots; arnica and sulphur in yellowish ones; belladonna, cocculus, phosphorus, in red blotches; carbo animalis, in copper-colored plaques will be of service.

Lycopodium in ephilides has given results that deserve repetition.—*L'Art Médical*, No. 3, 1893.

TWO CASES OF PUERPERAL MANIA.—Dr. W. Heyberger was called to a woman of 37 years who, seven days after a severe and protracted labor, broke forth into a maniacal attack, raged, laughed, wept and cried out. She attempted to escape through the door and window the entire first night. At daylight she quieted somewhat, yet continued to quarrel; tried to get upon the table, wanted to lie upon the floor, put herself upon the defensive when her escape was interrupted, broke the dishes, so that her friends were forced to bind her to the bed, where she seemed, at all events, unwilling to remain. She grabbed at the physician's watch chain, but let it go when her attention was turned to something else. Her eyes were tigerish and her whole aspect was malicious. Face reddened, pulse over 80, and constipation. Hyos. 3x and hell. 3x brought no change in three days. Her raging continued, her face was so hot that a cold compress made no impression, and her brown eyes glittered. Pulse, 90; aconite 2x and atropine 5x, at first every four hours and then twice a day, and finally once a day, brought about a recovery in fourteen days from the beginning of its outbreak.

A second case was that of a 30-year-old laboring woman who, after a normal labor, left her bed, to work in a potato field, on the fifth day. She was seized with fever, malaise, and her lochia ceased entirely. Acon., bell., and puls., seriatim, removed this. She returned to her work and developed a hyperæmia of the cervix, vagina and uterus, with violent pain, heat and swelling which, with great distension of the abdomen and sensitiveness, were relieved by belladonna. Fourteen days after labor the inflammatory symptoms were gone and her lochia scanty. She lay apathetically on her bed, wanted to hear nothing of her child, did not wish to suckle it, as she was about to die. Raved about her death, burial, and whether God would forgive her, prayed, laughed, suddenly, in the intervals, and determined to take her life if she did not die soon. She complained of a dull headache, otherwise no pain. Face pale, though her vertex and occiput were hot to the touch. Cold compresses were applied to her head, horse-radish poultices to her feet and the calves of her legs; aconite 2x and atropine 5x given in alternation every three hours. The night was passed restlessly; she cried out, raved, and was with difficulty held from running into the street. The next day the usual remission recurred. Quieter, but busy with kneeling and praying, but always ready to escape. Stramon. 3x was given, a powder every three hours. The next night was quieter. This drug was continued for the remainder of the treatment, and in twenty-five days from the beginning of the outbreak she was in full possession of her health and senses. Profuse sweating accompanied the advance to recovery.—*Allgemeine Homœopathische Zeitung*, Nos., 13, 14, 1893.

JATROPHA CURCAS produces a closer picture of cholera than does *Veratrum*. It causes vomiting of ropy albuminous matters with purging.

THE HAHNEMANNIAN MONTHLY.

JULY, 1893.

A CONTRIBUTION TO THORACIC SURGERY.

BY HENRY L. OBETZ, M.D., ANN ARBOR, MICHIGAN.

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IN the wonderful progress of modern surgery, every anatomical field has been worked over until at this time there remains but one where the principles are undeveloped, and where experimental research and increased clinical experience must develop new paths before we can relieve humanity of many ills, cured in other parts of the human body by local operations, and which, reasoning from analogy, should be cured by like means in this.

The field is that of "Thoracic Surgery."

Every accessible point of the cranium has been invaded, the outer bony covering ignored and found not to be in the way of reaching deeper parts, exploration of the brain finds it tolerant, abscesses can be aspirated or incised and drained, new formations, not only on its surface but in its substance, can be safely removed; convolutions of the brain found diseased or abnormally irritated, have been boldly excised, and the patients not only live but return to the walks of life restored to health and usefulness.

It was found that certain diseases of the kidney were amenable to

operative influence, but this did not cure certain other supposedly incurable conditions which, after great suffering on the part of the patient, always ended in death. The new fact that a kidney could be removed and the other could and would do its work, broadened the regional operative field, until now tuberculosis of the kidney can be cured with relative certainty by its excision.

A single ovarian cyst successfully removed by abdominal section demonstrated the feasibility of attacking an intra-peritoneal disease. From this small beginning has grown up the great field of abdominal surgery. The death-rate was high at first, but as compared with the death-rate of the diseases sought to be cured, meant the saving of thousands of lives which would have been lost or doomed to hopeless invalidism. First one, then both ovaries, then the uterus and ovaries, were removed and the operations perfected and classed among remedies for the relief of disease.

Next, the liver, stomach, spleen and intestines came in for their share of attention, until now, given a condition affecting any abdominal viscus, and we have the remedy at hand, in a carefully planned operation, depending on experimental research and clinical experience of the broadest and most elaborate kind. I might go on into other fields, all of which have been as carefully worked, and the results recorded for the benefit of the profession present and future.

Regional surgery, then, is in its infancy when applied to the thorax, but I feel confident that the day is not far distant when we shall see many supposedly incurable affections of the thoracic viscera cured by practical operations based on sound principles to be established in the near future. The need for pushing operative work to a greater degree of perfection here is very great, and thousands of lives, now lost, may, with a material advance, be saved. Experience in general teaches us that tuberculosis is, for the most part, a local disease in its first stages, and can be eradicated by radical local treatment. If by any possible means we ever arrive at a point where the ravages of this disease can be stayed by surgical means when it attacks the lungs, the saving of human life resulting will be greater than from any other single operation known to surgery.

Many other conditions here demand mechanical interference, and the principles governing some of the operations, and the operative technique, is more or less definitely established at this time, but no operation here has the same wealth of experimental observation, and clinical experience based on it, as in the examples cited in other regions amenable to surgical treatment.

The reasons for the hesitancy and delay in attempting surgical interference in this region are partly anatomical and partly clinical.

The structural difficulties are to be found in the conformation and make-up of the chest. In the inverted cone containing the vital organs we have the flexible yet practically immovable spinal column as a centre, flanked on either side by the ribs and their attached muscles. The ribs are elastic and movable in some respects; firm and resistant in others; so imbedded in the thin muscles attached to them as to be a part of a general whole, leaving the chest cavity but thinly covered when removed. If the ribs are not removed they prevent collapse of the chest wall, and the physiological rest so essential to the healing of any area after operation.

Clinical reasons are found in the insidious onset of many chest affections. The extreme difficulty of locating and determining the first stages of the formation of abscess, and of determining the exact location and extent of the diseased area.

Patients having pulmonary tuberculosis are, as a class, most hopeful, and underestimate the dangers confronting them. They have no fear of death, as a rule, though threatened with impending dissolution, and insist that they are better, and have great hope of cure as soon as this or that refractory organ, usually the stomach or liver, shall have been toned up and made to do its duty.

Operations on the chest are the most formidable ones the surgeon is called on to do. The stoutest-hearted observer of such an operation is appalled at the struggles of the patient for breath; at the convulsive cough caused by the reflex irritation resulting from the injury inflicted on the structures of the chest wall or lung.

Blood is blown through the opening into the pleural cavity by the convulsive efforts of the patient, and the operator and assistants are covered with its crimson spray. Syncope may threaten, and the deathly pallor but too plainly indicate the presence of the grim destroyer. Again, fluids are drawn or forced into the trachea, and the livid, bloated countenance and cessation of pulse and respiration show that death is threatened from asphyxia. In no other class of cases have surgeons been called on to record so many sudden and unaccountable deaths from slight operations.

No wonder that patients shrink from such measures even when life is in danger and the procedure is a necessity, nor is it a wonder that the medical adviser hesitates, and is loth to urge operative measures in chest affections as long as delay seems possible. It is this very delay—the putting off until the very last chance of the patient

is gone—which gives the high death-rate to the operation of *dernier ressort* in this region.

Experience and experimental observation teach that, aside from the effects on the lung caused by free-air pressure, the size of a wound in the chest makes no difference. Thus, after a small opening in the chest wall the lung may not collapse. If the opening in the chest wall is larger than the opening in the trachea of the patient, the lung does collapse.

It is also a fact, borne out experimentally and by the history of accidental injuries of the chest, that both pleural cavities may be opened at the same time without ending in the death of the person so injured. We have numerous examples of this in the history of gunshot-wounds both in civil and military practice.

A case of this kind came under my observation in which a pistol bullet of large size entered the chest under one armpit and came out at the same point on the opposite side, completely traversing both pleural cavities, and by some means missing the great vessels of the chest. The patient had abundant evidence of injury to the lungs, followed by some traumatic pneumonia, but after a time recovered, and since has been perfectly well.

South, in his notes in Chelius's *Surgery*, relates the case of a man pinioned by the shaft of a chaise, which was thrust entirely through both pleural cavities, and after a severe illness he recovered and lived ten years.

He further quotes a conclusive case of a gun-shot injury from Home, who relates the case of a man shot through both lungs, who recovered and lived thirty-two years. After death post-mortem examination verified the fact of the wound of both lungs by the bullet.

In part first of the *Surgical History* of the late war, we have a number of such cases reported but it is unnecessary to repeat them here. I only wish to give evidence of the single fact that both pleural cavities can be opened at the same time, and both lungs wounded as well, and yet the patient recover.

Parts of the lungs have been removed after injury of the chest wall leaving a hernial protrusion of the lung.

I refer to these cases, that we may study the methods by which this was done and the results which followed.

In his chapter on wounds of the lungs, I find the following cases cited by Cooper. See *Dic.*, page 485. He says, the protrusion of a portion of the lungs, in consequence of wounds penetrating the

chest, is a very unusual case: but there are some instances recorded by writers. Schenekius relates an example taken from Rolandus. He was called to a man who had been wounded in the thorax six days before. A portion of the lung protruded in a state of mortification. Rolandus extirpated it, and the patient soon recovered.

Tulpius has recorded a similar fact. A man received an extensive wound just below his left nipple. His naturally gay disposition led him to neglect the injury; and on the third day a piece of the lung three inches in length protruded. The patient went to Amsterdam which was two days' journey, for the purpose of receiving aid in one of the hospitals of that city. The protruded piece of lung which was already mortifying, was tied and cut off with scissors. It weighed three ounces. The wound healed in a fortnight, and the patient experienced no complaint afterwards, except a slight cough, with which he was occasionally troubled.

He survived the accident six years, leading a wandering drunken life. After death nothing particular was observed in the thorax, except that the lungs had become adherent to the pleura, in the situation of the wound.

Hildanus related another case; a man was wounded with a knife between the fifth and sixth ribs near the sternum. As a piece of lung protruded at the opening and was of a livid color, it was extirpated with the actual cautery. The wound was then dilated, and the ribs kept apart with a wooden wedge, under which plan the portion of lung girt by the opening shrunk within the chest. The patient was soon completely well.

A fourth example of a protrusion of a piece of lung through a wound in the thorax, is among the cases recorded by Rnysch. The servant of a seafaring man was wounded in the anterior and inferior part of the chest, and was immediately attended by a surgeon who mistook the protruded piece of lung for a portion of omentum, and applied a tight ligature around it. Rnysch who was consulted soon detected the mistake which had been made, but he delivered his opinion that the wound would heal very well, as soon as the tied piece of lung was detached. The event justified his prognosis and the patient recovered. He continues:

"After the battle of Waterloo I had a patient with a protrusion of a piece of lung, four or five inches in length. The part was much bruised, and could not be easily reduced. I therefore applied a ligature round its base and cut it off. Previously, however, I made an incision in it, in order to ascertain whether it would bleed

freely, which being the case, induced me to use a ligature. I was afterwards informed by my friend, Mr. Collier, that the man died.

"A more recent case is reported in the London *Lancet* for the year 1886, page 466, where a case is reported by Dr. Demons, of Bordeaux, France, of resection of a portion of the left lung with the *écraseur*, followed by hæmorrhage which was controlled with the thermo-cautery. The patient had been injured during a quarrel with a knife; after the operation on the lung it was also found necessary to remove the left kidney. The patient recovered."

Thus of six cases here cited, five recovered and one died.

The lung was removed by ligature three times with two recoveries and one death. The remaining other cases which all recovered were removed by excision, by cautery, and by the *écraseur*.

These were all clearly operations of necessity, but convey information which must prove useful and instructive as to method in developing operations of choice undertaken for the relief of disease. I cannot refrain here from calling attention to the fact that numerous cases are reported where patients having phthisical symptoms are said to have been cured by gun-shot and other accidental wounds of the chest.

Thus well marked symptoms of phthisis, asthma and chronic cough are reported to have been radically cured or greatly relieved by the rough medium of a gun-shot wound. (See notes, *Medical and Surgical History of War of the Rebellion*.)

Some tabulated lists of cases are reported of operations on the lungs for tubercular and other diseases. I shall not attempt to collect them, but rather to select such cases as serve to give the technique now in vogue, and by comparison with some of my own cases, show wherein I think the present methods are faulty and subject to criticism. I shall further suggest measures which I think if adopted will give us a better command of the field, and lead to a more extended practice.

The most valuable and comprehensive account of thoracic operation up to this date is embraced in the lectures of Rickman J. Godlee, published in the London *Lancet*, vol. 1, for the year 1887.

In his first lecture he asserts that, "in some forms of pulmonary abscess surgical interference is obviously inadmissible; nothing, for instance, can be hoped from it, in treating the lung which is riddled by numerous tubercular cavities or the multiplied gangrenous foci which occur in the course of embolic pyæmia."

Those in which surgery has been, or may be attempted, may be thus classified :

First.—Tubercular cavities.

Second.—Cavities resulting from gangrene of the lung.

Third.—Cavities resulting from the bursting into the lung of abscesses or other collections of irritating matter from without.

Fourth.—Bronchiectasis, from whatever cause arising, and including those which depend upon the presence of a foreign body in the air passages. He follows with an interesting detail of historical references on the subject, showing the various attempts made by surgeons to cure abscesses and pulmonary cavities left by them by operation. Of the cases cited by him the following alone can be quoted here as being in the direct line of thought I wish to pursue: He says:

1. F——, æt. 40 years, advanced phthisis with large cavity at left apex.

Resection of the third rib to allow the chest wall to fall in. The patient lived a little more than a fortnight. Some retraction is said to have occurred.

2. F——, æt. 15. Advanced phthisis, with consolidation and excavation of lower lobe of the left lung.

Parts of the second and third ribs were excised, and threads were passed through the pleura into the lung in order to ensure adhesions if these were not present. Four days later an attempt to reach a large cavity resulted only in the discovery of a small one. The operation appears to have had but little influence on the progress of the disease. The patient died three weeks after the first operation.

3. F——, æt. 25. Advanced phthisis, cavities in the left upper lobe.

Parts of the second and third ribs were removed, and a large cavity was opened. The cough and expectoration were very much relieved, and the cavity decidedly contracted; the patient living five weeks after the operation.

A far more heroic method of dealing with tubercular lung has been in recent years suggested by certain Italian surgeons who have made this subject a specialty, though it has been followed up by some observers in Germany.

Dr. Domenico Biondi showed first the possibility of an animal surviving the complete extirpation of a healthy lung, and then proceeded to demonstrate that the same might be done in an animal the lung of which had been previously inoculated with some of the sputum of a tubercular patient, and had actually become the seat of tubercular changes.

A very considerable proportion of the animals (rabbits, cats and dogs—twenty-one in all) died as the result of the first or the second operation, but some survived and lived for a very considerable time afterward.

The dogs and cats were not very favorable subjects for the development of tuberculosis, but it is remarkable and interesting that in some of the rabbits tubercle was actually developed in the lung which was removed, and after the removal the animal remained free from further development of the disease.

The conclusion that the author wishes to draw is obvious, but he hardly ventures to hint at the application of the treatment to the human subject, and it can scarcely be expected that it will ever be placed among the recognized surgical procedures. It could only be applied in the early stages of phthisis, when the disease may be considered within the possibility of a practically permanent cure by other and simpler means. And indeed the same may be said of another possible deduction, namely, the removal of tumors of the lung. Diagnosis must clearly reach a much greater pitch of refinement before the physician could counsel, or the surgeon attempt, the removal of a primary tumor of the lung, rare as it, and difficult as it must always be to discover in its earlier stages, when alone it could conceivably be extirpated. It must, however, be stated that in two cases of phthisis parts of the lung have been actually removed by Ruggi—one of the patients dying in a few hours and the other on the ninth day. And not only so, but tumors of the lung also have been removed, though it must be owned that the experience of the surgeons who undertook the operation is not very encouraging.

Weinleicher, in 1882, removed a round tumor as large as a man's head from the thoracic wall of a man aged 37, leaving a huge gaping opening into the chest and taking away a part of the lung to which it was adherent; the patient died twenty-four hours afterwards.

Kroenlein also removed a recurrent sarcoma in the same situation from a girl, aged 18, taking away part of the sixth rib and some adherent lung. The end of this case is not reported in the interesting article of Albert's from which the reference is taken.

Gangrenous Cavities Resulting from Pneumonia.—These cavities are perhaps the most promising with which the surgeon is called upon to deal, especially if operation be not too long delayed. In the course of time, if the patient survive, the surrounding lung becomes condensed and inelastic; but in the earlier stages of the

disease it retains more or less its normal characters, and the walls of the cavity are able to fall together like those of an abscess in the soft parts elsewhere. But delay is almost unavoidable, on account of the great difficulty of localizing the position of the cavity with precision, and the still greater difficulty of ascertaining the absence or the presence of adhesions.

I do not think that the second point should be allowed to influence the surgeon in the direction of delay, and certainly should not interfere with an exploratory puncture, because, in the first place, experience shows that even adhesions which have been accurately diagnosed by the most competent observers may, after all, be found to have no existence, and, in the second place, it seems clear that exploration with an aspirator needle may be safely made through a patent pleura, even if the instrument pass into a collection of putrid pus.

I do not say that mischief will never follow this procedure, and I am sure that it is wise to ascertain for certain the condition of the pleura before making a free incision into a lung containing septic pus; for if the non-adherent pleura be opened, and through it a drainage-tube be passed into a putrid cavity, very serious symptoms may result. This was well illustrated in a case of bronchiectasis, where we had ascertained, a week or two previously, that there was some clear fluid in what was thought to be merely a remnant of the pleural cavity. On cutting through the intercostal space it was found that the two layers of the pleura had become adherent since the preliminary puncture, but only by very weak adhesions, which easily broke down under the pressure of the finger and the expiratory efforts of the patient whilst the opening was being made into the bronchiectatic cavity.

This led to the opening up of a large remnant of the pleural sac, the walls of which were non-adherent, and the consequence was that the pus from the bronchiectasis escaping into the pleura set up a septic pleurisy, from which the patient nearly died.

It will be well, therefore, to consider at the outset what should be done when these adhesions, so commonly but yet not invariably found, are wanting. One plan would be that mentioned above as recommended by De Cernville as a precautionary measure—namely to pass needles armed with silk through the pleura into the lung; but as in almost all cases the lung is solidified, and will, therefore, not fall away to any extent from the thoracic wall, even if no adhesions at all be present, I do not think that this, though quite unobjectionable, can be considered to be a necessary precaution.

The right method of procedure, though I confess it is not a very easy one, is carefully to stitch the lung up to the opening which has been made in the chest walls. It is a difficult proceeding, because the parts are in a constant state of movement from the act of respiration, and because the lung itself is but ill-suited to retain the stitches that are placed in it, and also because the hole in which the manœuvres have to be carried on is a rather deep one, and mostly obscured by the presence of blood. I have only once had to put this plan into practice, and though here it was only partially successful, it was sufficiently so to show that, with a little more care, the closure of the pleura might have been effected. We found, in this case at the end of a few days, that a part of the stitching had given away, but as no cavity was reached, no evil consequences as regards the pleura resulted, the wound remaining antiseptic.

Of course, after the stitches have been placed, the attempt to open the cavity must be postponed for at least a week, and at the end of that time the instruments used must be sharp, and their employment gentle, lest the accident which it is intended to avoid may, after all, happen.

In his second lecture he quoted the following cases from Copeland and closes with the remarks which follow the report of the cases.

1. A boy aged 17, swallowed a bone in November, 1883. He developed bronchiectasis, but completely recovered after coughing up the bone in February, 1884.

This, I think, is most instructive, not only as showing that the bronchiectasis and induration of the lung, which had taken four months to develop, could be completely recovered from, but as indicating the line of treatment in such cases.

2. Dr. Magrath's case, where a piece of grass became impacted in the right lung of a boy of seven. Death occurred after ten weeks. The lower lobe of the lung was riddled with abscesses. The diaphragm (as in one of my cases) had been perforated by the abscesses and there was secondary caries of the spine.

Dr. Gayley's case, which was one of a low form of pneumonia, resulting in a basic cavity containing five or six ounces of offensive pus and sloughs of lung substance. He had only been ill for five weeks, but had the appearance of a man in the last stage of phthisis. The cavity was opened in the ninth interspace, but the case ended fatally, being already too far advanced. There were signs of old tubercular mischief in the lungs.

4. Dr. Solomon Smith, of Halifax, records a case where gangrene

followed acute pneumonia, and where death followed an incision into the abscess after nine days.

5. Dr. Gayley's case of a gangrenous abscess following ear disease, in which Mr. Gould punctured the abscess with a trocar, but on introducing the tube, failed to drain the abscess at first; it afterwards, however, burst into the artificial opening and the patient made a good recovery.

6. Some cases are recorded in a paper read by Dr. Mosler, before the German Medical Congress at Wiesbaden, in 1883, in which he recommends the incision of the lung with the actual cautery for the extraction of foreign bodies.

I am not able to strongly endorse this advise (though with deep incisions it may possibly be advisable), for the use of the knife does not, as a rule, lead to formidable hæmorrhage and the charring of the tissues must cause considerable difficulty in any exploration with the finger.

7. Dr. Ed. Bull, of Christiana, records a case of circumscribed gangrene of the lung, which was opened successfully.

It may be taken for granted, then, that the majority of the cases of gangrenous abscess which come into the hands of the surgeon are the result of acute pneumonia, and are situated near the base of the lung; and it may be added that his aid is most likely to be needed in those cases in which the gangrene is not very extensive, so that the patient survives the immediate effects of this process. Some of these cases, it is well-known, recover spontaneously, the pus being expectorated; but in others a condition of things results such as is often met with in abscesses bursting spontaneously in other parts of the body—namely, that the opening being insufficient, and, perhaps, unsuitably placed, the sac is always more or less filled with the discharges, which in the cases we are considering are always highly septic, and, therefore, irritating. The abscess, consequently, shows no tendency to close, but on the contrary, increases in size. It is not a good plan in such cases to wait long before making the external opening—that is, if the position of the abscess can be accurately determined,—because as pointed out when the subject of empyema bursting into the lung was discussed, the presence of foetid pus in the bronchi and trachea is very likely to lead not only to serious consequences in the diseased lung, but also in the sound one; but, at the same time, it is not often wise to make an incision through the chest wall until the situation of the abscess has been ascertained by means of an exploring trocar, and even then the troublesome question of

the presence or absence of pleural adhesions has to be settled before the lung itself is incised.

Another case in point is the following:

Resection of the lung in incipient tuberculosis, and operation for hernia of lung.

On May 5, 1891, M. Tuffier resected the lung of a man aged 25, with incipient phthisis apparently limited to the right apex. He made an incision in the second intercostal space and exposed the pleura. In order to draw the apex more easily through the small incision he produced an extra pleural pneumothorax by separating the parietal pleura from the chest-wall around the apex; the membrane was lightly torn, and the hole was stopped with the finger, and then with gauze so that but little air entered the pleura. The apex of the lung was then seized with special forceps and drawn out. The area of consolidation, which was about the size of a large hazelnut, firm in the centre, and slightly granular at the circumference, could be distinctly felt and defined. A silk ligature was then tied tightly around the protruding lung, five centimeters from the apex and two beyond the area of consolidation; the lung was cut off, and the pedicle accurately sewn to the periosteum of the internal surface of the second rib, so as to avoid the production of pneumothorax. The divided muscles, layer by layer, were then carefully sutured with catgut; Florence hair sutures were used for the skin wound, and an iodoform wool dressing was applied. The patient was under chloroform for thirty-five minutes, and there was no disturbance whatever of the breathing or the circulation. An excellent recovery followed without fever; cough, or any sign of reaction, local or general. The dressing was first changed on the sixth day; and beyond slight weakness of the breath-sounds over the whole lung, no abnormality could be detected. The dressing was left off on the ninth day, when the patient was well enough to be exhibited. On November 30, 1890, he also performed an operation for radical cure of a spontaneous hernia of the lung, returning the lung and sewing up the wound; the patient was well by the seventh day.

I shall include resection of the lung or pneumonectomy and incision of the lung or pneumotomy under the same heading, as I believe the same method of attack should be made in each.

"A patient presented himself at London Chest Hospital with pain, cough, and shortness of breath. Examination showed absence of movements of left side of chest, with anterior and posterior dullness; tubular breath sounds with vocal resonance and fremitus in-

creased, right side healthy. In the course of a few days the temperature ran up from normal to $100\frac{8}{10}$, but soon fell again; night sweats with a free foetid expectoration set in. At the suggestion of Dr. Samuels, an aspirator needle was inserted between the fifth and sixth ribs and two ounces of foetid pus drawn off. Considerable tumefaction at the point of aspiration followed, and a free incision was decided upon. About three ounces of pus escaped; and a drainage-tube inserted. Until this time it was thought the pus came from the pleural cavity, but when a few days later a portion of the seventh rib was resected, and the thickened pleura incised, it was shown that an abscess of the lung about the size of an orange was the source of the pus. The cavity was washed out with a solution of perchloride of mercury 1-500 and a drainage-tube inserted. The patient began to improve in every respect; but on the evening of the fourteenth day he was suddenly seized with an epileptiform attack, followed by paralysis of the right arm. In an attack similar to this, a few days later, he became unconscious, was completely paralyzed, and died five days later. Post-mortem showed healthy granulations in the cavity of the lung. Smaller abscesses were found in the upper portion of the lung.

“The disease undoubtedly originated in pneumonia, and the close proximity of the pleura caused an extension of the inflammation and adhesions. Abscesses of the brain, the cause of death, were undoubtedly embolic in origin, which is claimed to be the rule in abscesses of the lung or pleura.”

I have now done some twenty operations on the thorax, major and minor. Of these but two could properly be reported here, as illustrating some points which I urge in the text further on. They are as follows:

April 9, 1888, was called by Dr. F. X. Spranger to see Mrs. F——, æt. 40. Married.

History.—Seven weeks previously while visiting in a southern city was taken with fever of a continued type. The doctor in attendance pronounced the disease “malaria,” and treated the case on general terms as a common case of malarial fever; as the patient did not improve, she was advised to come to her home in the north, trusting that the change might be of benefit. On Dr. Spranger’s first visit he found the patient emaciated, weak, pulse and respiration quickened, respiratory murmur faint in lower lobe of left lung, although not entirely absent. Marked tenderness on pressure, and the patient stated that there had been a deep-seated soreness and a little pain in

this side from the first. This had been ascribed to the stomach by her attendant. Morning temperature 101, evening 102 to 102½. Percussion elicited some dulness over lower lobe of left lung, no increase in size of side or bulging of the intercostal spaces. There was some cough with expectoration of muco-purulent type. During the whole sickness the patient had experienced light chills at irregular intervals. After consultation we decided that the condition was one of localized empyema, or pulmonary abscess affecting the lower lobe of the left lung, and decided to attempt to locate it with the aspirating trocar. April 12th, under the influence of chloroform the exploration was undertaken.

I selected the space between the seventh and eighth ribs, in the centre of axillary line, as being at about the upper level of the area of tenderness. Introduction of aspirating-needle 2½ inches straight in gave a negative result; then the needle was withdrawn from the lung and reintroduced downward and backward again with no result. Again I withdrew it, and this time thrust it downward, inward, and forward, and this time was rewarded with a few drops of thick, foetid pus. It was determined at this consultation to operate on the case, and the operation was fixed for the next day at 2 o'clock.

Operation.—The anæsthetic used was chloroform, and beyond the effects of shock and irregularity of respiration during the last part of the operation, there is nothing in regard to the anæsthetic worth recording. I commenced by making a four-inch incision over the seventh rib, from the axillary line forward. I next removed the periosteum and attached muscles; for cutting the rib I used the common rib-shears. I now attempted to open the pleural cavity in the rib space, but found, at the point of attack, the union between the pleural surfaces so intimate that this was impossible.

Explorations further up gave me an opening through which I thrust my index-finger. I found the lung intimately adhered to the chest-wall at all points. I now dissected the lung from its attachments, opening the cavity to the full length of the space from which I had removed the rib. I now directed my finger towards the diaphragmatic attachment of the chest-wall, dissecting my way carefully and thrusting back the lung. The struggles of the patient at this time were very great, and the bleeding as the adhesions gave way quite free, as the edge of the lung folded up. I found the adhesions continued over the surface of the diaphragm. Suddenly I broke into a large cavity having its base on the diaphragm and its

apex in the base of the posterior lobe of the left lung. There now came a great gush of badly-smelling and very thick matter. During this part of the operation Dr. E. P. Gaylord, who had charge of the anæsthetic, pronounced the patient very weak, and stopped it temporarily, lifting out the tongue to aid respiration. Dr. Spranger held the ribs well apart with stout curved retractors. I now, with the finger, separated all adhesions to the diaphragm and costal pleura as far up on the upper side of the wound in the chest-wall as I could. I did this to allow the lung to collapse and thus get it up out of the way in order to better drain the cavity. The lung was partly infiltrated with inflammatory matter and contracted some, but to no great degree. With the finger as a curette I removed all flakes of fibrin and granulations in sight.

With the finger I drew the lung into the opening and trimmed the abscess edges just as I would have done in any other region. We were satisfied that the cavity had an opening into a bronchus, and the great problem now was whether it would do to wash out the cavity. This I did with a mild boracic acid solution, at a temperature of 100° , keeping the wound fully dilated all the time and allowing a free out-flow of the water. This done, I inserted a flanged drainage-tube at the lower angle of the wound, left the wound open and enveloped the whole side of the body in an ample antiseptic dressing, consisting of gauze, mackintosh over this to distribute the discharge, and lamb's wool over all. The patient reacted well, the pulse improved, the temperature fell to normal. On the seventh day the dressing began to smell and the first change was made. Found the cavity smelling quite badly, but little discharge. With the patient in a sitting posture, we used a claret-colored solution of permanganate of potash. We allowed the cavity to fill from below until the patient coughed, when we stopped the flow and allowed all the liquid to escape; the cough brought sufficient of the solution through the bronchus into the mouth to color the saliva. After this, as often as the cavity became foul, we repeated the irrigation, and to the very last time the patient was able to raise some of the solution. The general progress of the case was good, and by the middle of May the opening had granulated and the patient was well. Her health has remained good.

A. M., aged 19, patient of Dr. Isaac Bentley, was one of the victims of the Tilden School fire, and was severely burned about the hands and face. Inhaled flame and smoke and complained constantly of left lung for months afterwards. In July, 1890, was

taken with several other members of this family with typhoid fever.

The fever in this case was rather more severe than in the others, and about the middle of August he was taken with a sudden oppression of breathing and constitutional symptoms of hæmorrhage. On examination, Dr. Bentley found a large accumulation of blood pushing down the diaphragm and filling the left pleural cavity. It was at this time that I was first consulted. I confirmed the diagnosis, and as the bleeding had stopped I advised delay for the present. August 19th, the oppression of the breathing having increased to such an extent as to cause great embarrassment of respiration and circulation we decided to tap him. This was done under strict antiseptic precautions, and three pints of liquid blood drawn off. The patient was much relieved and seemed better for some days. Ten days later was again called and found the patient again suffering from oppression of breathing. Tapped again and drew off about the same amount of blood. I left with Dr. Bentley, the patient being very comfortable. Two hours later, I was hastily summoned, and found the patient had suffered from another severe hæmorrhage, the side being tightly distended and diaphragm pushed down, making a rounded, fluctuating tumor in left hypochondrium. The patient was suffering from combined blood loss and pressure, and his friends were told to prepare for the worst. His death seemed sure. After hard work on the part of his attending physician he rallied, and, except for the pressure symptoms, his condition was much improved. At the request of the family, Dr. E. L. Shurley was called in for consultation, September 4th, and, after examination, agreed that the bleeding proceeded from an abscess of the lung, advised a third tapping. This the patient and friends refused to allow, the friends being particularly against doing anything further. Four days later I was again called and found the pressure symptoms much worse, the patient being in such agony that he not only consented but demanded that something should be done to relieve him. The patient was given chloroform, and on introducing the trocar the contents of the thorax was found to be pus. Free incision was decided on, and the space between the seventh and eighth ribs in the axillary line chosen to make the opening. Incision made, measured three inches, and a full gallon of pus flowed slowly through the wound. The patient rallied well, and was much relieved. Dressing changed four days later; some discharges; new tube inserted, and wound redressed. Patient seemed to do fairly well until

October 11th, when I was called again. The tube was still continued by Dr. Bentley, but on examination it was found that it no longer drained the whole cavity. Adhesions had formed a second cavity, which occupied the upper half of the pleural space.

The patient was again placed under chloroform, and the space between the fourth and fifth ribs selected as the base of the accumulation. Opening two and a half inches long entered a cavity holding a quart of very offensive pus. Both the old and new cavities were now thoroughly washed out with claret colored permanganate of potash solution. Daily irrigation with calendulated water was kept up. The patient did not seem to improve, the pulse being weak and as high as one hundred and forty beats per minute, respirations ranging from 24 to 36. Temperature from 102 in the morning to 104 in the evening. The patient seemed in desperate straits, and I decided on radical measures. Accordingly, on December 2d, one month and twenty-one days after my last operations, under chloroform, I resected four inches of the fifth rib. I now opened the upper cavity through the rib space and with my index finger broke down the adhesions dividing the pleural space as far back as the finger could reach. I next turned my attention to the stump of the lung in the posterior part of the upper cavity. It seemed firmly adherent in all parts and completely solidified. With the finger I broke up all adhesions and pockets around it and finished by washing out the cavity with a warm boracic acid solution.

The patient's surroundings were not the most favorable, his parents living in a small cottage heated by soft coal stoves. After much urging he was removed to St. Mary's Hospital and placed in charge of the Sisters. The upper opening now ceased to discharge, and tube was withdrawn. His general condition began to improve, and by the middle of January he returned home cured. Examination at this time shows the lung to have fully expanded and no trace of the trouble left but the scars which mark the lines of incision.

Operation.—May be undertaken, when there is a lung-cavity due to bronchiectasis, gangrene or hydatid, and it is evident that drainage is imperfect.

The case is urgent, when the expectoration is profuse, foul and irritating; when the cough is constant and irritating; when sleep is interfered with, appetite is poor, or lost; when there is diarrhoea, night-sweats, chills, or the commencement of hectic fever.

The operation should be undertaken before the whole lung is infected, and when only one lung is diseased.

Anæsthetic.—I have now imperfect notes of more than twenty cases of thoracic surgery, and have used chloroform in most of the cases. In those with weak heart-action I have used narcosis from whiskey, using from 6 to 12 ounces, according to the age and condition of the patient and the degree of effect desired. In every case the whiskey is supplemented with small doses of chloroform, as needed to keep the patient in the operative stage of narcosis.

Care should be taken not to allow the patient to rise up suddenly during the excitement from the anæsthetic, and in lifting the patient from the bed to the operating table. Care should be exercised lest the patient be doubled up, or the chest constricted, thus forcing fluids into the trachea. I have seen at least two patients almost drowned in this way.

Incision.—It will be seen from the cases taken from current literature, that small incisions have, so far, been the rule. Much stress is laid on the fact of determining the existence of adhesions, and where these are absent it is advised to first stitch the lung to the costal pleura, and wait until adhesions form, before proceeding to open the cavity. It has always seemed to me to be timid and unsurgical, if we have sufficient grounds upon which to base the operation in the first place.

In the cases reported by me, I violated all these rules, and now, looking back, I do not think I did as good work in either case as I might have done with a larger opening. In both my cases, I freed the lung from the chest-wall by tearing up all adhesions; in the first case it would have been necessary to incise the lung in order to reach the cavity; it would then have been imperfectly drained, from its shape and situation, and could not have contracted as rapidly as it did after loosening it from its attachments to the diaphragm. In the second case, the patient did not improve, but remained very ill until I tore up the adhesions, and from that time on he constantly improved.

I think all adhesions should be broken up, and the whole cavity thoroughly drained. I do not think we have greater cause to fear septic pleurisy after thoracic operations than we have cause to fear septic peritonitis after abdominal operations where pus, or other irritating fluids, escape into the peritoneal cavity, and we avert all trouble by thorough irrigation and complete drainage. Now, as to the opening in the chest-wall. Is it not possible that, in the future,

if we can find a feasible way to open the lung-cavity, that the exploratory operation for purposes of diagnosis will be both more common and more useful than it is now in abdominal surgery?

How, then, shall we make even a guess at the way this can be done so as to avoid the most important structures and yet give room to work with ease?

The opening should be so planned, and so large, as to give us complete control of the field, thus allowing us with the eye and finger to examine every part of the pleura and every portion of the pulmonary tissue. I have long been convinced that the ribs are the only bar to the complete mastery of the situation here; if there were no ribs, or if these could be dispensed with, dealing with the lung and its diseases would present no special difficulties other than those arising from its structure and physiological functions.

We need an opening here like that in the linea alba in abdominal surgery, one giving the minimum of danger and the maximum of usefulness. What this will eventually be we can no more than conjecture now, and it will take many trials and much work to finally perfect it, and make it stand the test of practical experience.

In a case of gangrene of the right lung resulting from whiskey-drinkers' pneumonia, which presented itself in the charity ward of Grace Hospital, Detroit, I determined to open the chest after the following plan if necessity demanded operative interference:

The case began to improve, and I decided to wait, after a consultation with a number of my colleagues. Three days after we came to this decision the patient while sitting up in bed became faint, fell back on her bed and expired. Post-mortem examination revealed the pleural cavity, foul, full of blood and covered with decomposed fibrin; the lower lobe of the lung necrotic. Death was caused by hæmorrhage from the bursting of a bloodvessel in the lung.

Plan of Operation.—To avoid the mammary gland I decided to commence an incision in front of the line on the coracoid process, and carry it straight across the ribs to the scapular line between the sixth and seventh ribs.

In order to miss the superior intercostal I decided to commence the incision over the second rib, but to make the third rib the upper margin of my flap. From the commencement to the end of my proposed line of incision I intended to divide all structures down to the ribs, and after controlling all hæmorrhage, to resect portions of each rib from the third to the sixth. I now proposed to carry an incision between the sixth and seventh ribs with scissors far enough

forward to give plenty of room, even if this point was at the junction of the costal cartilages with the ribs. By now carrying the incision along the junction of the cartilages and ribs to the upper border of the third rib, and from this point to the place of commencement, at the point where this rib had been resected, I would have my opening complete. I planned to allow the integument to be one inch broader than this flap around the whole margin, so that when the flap was laid back and stitched in place, the integumental suture line should not correspond with the line of incision into the chest wall. The great question, of course, was how to deal with the bloodvessels; I hoped to manage these with plenty of catch forceps, and to avoid the internal mammary by keeping well away from the sternum. I argued that my carrying my lower incision to the point of election would give me a perfect drainage-point; that by resecting the ribs in the proposed line I should make a trap-door flap with all the ribs in it, which could be lowered and thus completely open the cavity; that the free opening would allow collapse of the lung, thus rendering it easier to manage than when it does not collapse and moves with each movement of the chest as it does in the small opening.

Observation at the post-mortem examination convinced me that no smaller opening could possibly have enabled me to manage the gangrenous lung tissue. I intended to clamp and ligature it in mass, and then sear the stump with the cautery; or, by imitating the cases of hernia cited above, drag the diseased lung through the chest wall, confine it there, and allow nature to slough it off at the line of constriction. If this plan can be carried out at all, it may be possible to include the second rib when necessary, or a central section of this rib may be removed to allow it to contract and help to contract the chest wall after operation.

With this kind of an opening caseous masses could be felt and removed, dilated bronchi, when obstructed and filled with secretion, incised, drained, irrigated, the foreign body removed and the opening in the bronchus continuously drained by sewing in a bone drain, or closed with cat-gut. Abscesses could be incised, curetted and closed, or cauterized, to control bleeding, and left wide open to drain into the pleural cavity and heal by granulation.

If, according to Godlee, we may never hope to see a whole lung successfully removed, we may yet hope that large portions of necrotic tissue may be removed and the patient recover.

A word more about the sudden deaths from slight operations, and even from simple irrigation of the pleural cavity.

In many of the reported cases, death occurred after irrigation had been practiced many times. I think some of these patients are killed from shock caused by fluids too warm or too cold; others are drowned by fluids going into the trachea through an open bronchus, or that the lung floated on top of the fluid like a cork, empties partly pent-up secretions into the trachea suddenly, and thus causes death from asphyxia. Thus one of my cases became faint and livid, but on coughing brought up much pus and mucous, and at once felt better. Every portion of a thoracic operation and after-treatment should be guarded by strict observation of Listerian principles.

SUPPLEMENTARY REMARKS UPON SOME MEDICINES LITTLE USED
AND UPON THE UNUSUAL USES OF CERTAIN WELL-KNOWN
MEDICINES.

BY W. C. GOODNO, M D., PHILADELPHIA, PA.

(Read before the Germantown Homœopathic Medical Club.)

Two years since, in response to a request from the Hahnemann Institute, I made some remarks upon "Some medicines little used and upon the unusual uses of certain well-known medicines." I afterward reduced the lecture to writing and it was published in the *HAHNEMANNIAN MONTHLY* for January and February, 1891. What I said upon that occasion was received with much favor, and in response to many requests from all portions of the country I propose this evening to supplement that paper with further comments upon some of the remedies then treated, and a consideration of some additional medicines. Of the value of gelsemium in rhinitis, colchicum in typical rheumatic fever, cocaine in heart failure, especially the form of failing heart found in diphtheria, and infectious diseases generally. Of the value of the preparation of permanganate of potash, used locally, which was recommended in diphtheria, and of guiacum in simple catarrhal pharyngitis, etc., I have had additional evidence in my own practice, and much stronger evidence from numerous colleagues and physicians at a distance, who have been good enough to write me their results. I do not desire to weary you with undue reference to what I have before written, yet desire to call your attention to the paper in question and the following comments upon the same. I do this with the knowledge that most of our thera-

peutic practices have in their infancy, and even up to their maturity, had to struggle for existence, either against apathy, or excessive laudations. Colchicum, I had the honor of introducing as a remedy in rheumatic fever, and, therefore, feel a parental solicitude for its welfare. As before pointed out, the sphere of the medicine is emphatically *typical acute articular rheumatism*, and in its treatment this remedy is unapproached in value by any other medicine with which I am acquainted. This statement is based upon a collection of over 200 cases furnished by twenty odd practitioners. Most observers who have used colchicum, *just as it is recommended*, corroborate the above statement as to its value. A number of colleagues have failed to be able to express the unqualified praise here given to this medicine. I have investigated the reasons with some care. In these investigations I have been impressed afresh with the old statement that however good the tool, there must be intelligence behind it. Physicians use medicines intelligently only after a well-established acquaintance with such medicines. We all do, and always will do, a certain amount of prescribing of remedies which is imperfect or positively bad, if from no other reason than that we have not yet been able to gain enough knowledge of, or experience with such agents to enable us to secure the best results which may be attained. The first error is in prescribing for cases of *atypical* rheumatism. I have found this medicine most valuable in a variety of cases, even in rheumatoid arthritis of the terminal finger-joints, if given before deposits and visible inflammatory conditions are present, *i.e.*, when the joints are simply tender and have little shooting pains. Such a condition often precedes enlargement for some time, presenting exacerbations and remissions and ending in deformity. Several times have I seen these symptoms promptly controlled by a few doses of colchicine. I have not yet been as successful in arthritis of the larger joints, although my experience is yet too limited to express any positive opinion. The same may be said of gout. Perhaps I should say that by the term "typical rheumatic fever" I refer to the specific disease, *i.e.*, "acute inflammatory rheumatism," beginning usually quite suddenly, attended by marked febrile phenomena, several swollen and usually very painful joints, and with, in most instances, a tendency to sweats. If a person suffering in this manner is put between blankets and not allowed to leave their kindly protection for any purpose whatever, fed upon a light simple diet, and given colchicine in proper dosage, the certainty of relief is very great. Most are relieved by very small doses—say gtt. iij. of a gr. j. to 3j solution

repeated every 1 to 3 hours, according to the acuteness of the case. If I am called to a highly acute case in which the suffering is intense I do not hesitate to begin with gtt. v doses and repeat hourly until relief comes, unless the physiological indications of overaction appear (nausea, abdominal pains, diarrhœa). Many persons are insensitive to its action. I remember a case in which a colleague treated a case unsuccessfully for a week using gtt. v. every 2 hours. I suggested gtt. x., and finally gtt. xv. before success was attained. The latter dose was well borne and relieved the case slowly. It could hardly be considered as the best remedy which might have been selected for this case, but I relate it to show the action of colchicine in various doses. The 1st and 2d dec. dilutions, made from the θ (1 gr. to ℥v . alcohol) often prove promptly efficient, even in bad cases. This I hear from several observers. Colchicine undoubtedly acts most efficiently when used in doses which fall just short of developing its physiological action. The guard symptom is gastro-intestinal irritation. If given to this degree the medicine should be stopped at once and not repeated again until all symptoms of action have entirely subsided, then begin with one-half the dose which was originally administered, stopping again if symptoms appear. It is imperatively necessary to pay strict attention to these instructions if you employ the tincture at all, which you must do—at least in many cases, if you desire the best results.

I have, in several cases, to which I have been called of late—cases which have progressed to full development with intense suffering—given eighth-grain granules of morph. sulph. at intervals of four to eight hours, thus securing prompt relief from the agonizing pain during the twenty-four hours which is required for the colchicine to develop its control of the case. (In combination with morphia, much larger doses of colchicine may be given, if it is deemed best.) It is best not to notify the patient of the possibility of nausea, etc., developing, for, if nervous, the medicine may be stopped without cause. A little gastro-intestinal disturbance does no harm; rather, the opening of the bowels may do much good, and it must be rare that the giving of the doses suggested cause much annoyance, even to a susceptible patient, within the period intervening between two visits of the attendant. Much time is spent upon this portion of our subject, as I believe the best results are attained while treading upon dangerous ground (*i.e.*, danger of nausea, etc.).

One of the greatest enemies of this remedy is its own success. It must not be forgotten that acute rheumatism runs a definite and

rather protracted course ; that it is probably due to the action of a specific bacterium, which causes blood changes and their consequences, *i.e.*, fever, sweats, and local inflammation of certain fibrous tissues, that we can only control the disease as far as externals are concerned. If this be true, it matters not how much pain may be eased, local inflammation reduced, and the various symptoms brought under control, the germs still remain within the body, becoming more active upon a relaxation of the measures employed to control its multiplication and destroy its product. A relief of symptoms does not, then, indicate that the patient is emancipated from the disease. Until the specific organism has completed its life-history and disappears, there is possibility of relapse.

In the same article, I called attention to the use of permanganate of potash, as a local application in the treatment of diphtheria. The method of using the potash salt then suggested, has been widely employed, and with a degree of success which is very encouraging. I have just received a report from Dr. Charles Myers, of Manayunk, which I have brought with me, and will read to you. Dr. Myers lives in a region of the city which produces much diphtheria, and of a malignant type. I saw many of the cases reported by him, and can add my testimony as to their serious character.

I desire to call especial attention to the importance of the *early and thorough application of this remedy*. I have repeatedly been called to visit cases which have not been improving under its use, which have gained immediately upon its proper application. Sprays and douches are of little value, as the drug is not kept in contact with the diseased surface for a long enough time to accomplish what it is capable of. Great attention should be paid to the nose; on account of its peculiar construction, diseased products are retained, and readily absorbed. Thorough cleansing with peroxide of hydrogen spray should precede each application of the potash; this substance, *i.e.*, the peroxide of hydrogen, is a valuable cleansing agent, but exercises little influence upon the disease. If necessary, the nose must be cleansed with cotton and forceps; perhaps a post-nasal douche, before spraying with the peroxide. The failure to thus cleanse the nose is one of the most serious errors committed in the treatment of these cases. It is very difficult to accomplish in children, below a certain age, which is one of the causes of a large mortality in this class of patients. While working over these patients, it is best to cover the nose and mouth with a handkerchief moistened with a disinfectant.

During this winter I have several times followed the plan of packing the nose with the permanganate of potash trituration rather than simply *dusting* it upon the surface; cleanse first, then pack, using an aural or nasal speculum. When the membrane is dense, stronger preparations may be employed. If the patient is old enough to permit it, strong *solutions* of the permanganate may be applied directly to the affected surfaces. It is well known that the rapid decomposition of this drug destroys it, in great degree, as an internal medicine, and it is on this account less objectionable as a local application.

During the past three years I have been employing (as well as some of my friends) a drug which has not been introduced into the materia medica, and, so far as I am aware, has not been employed by any one as a medicine. I refer to the iodide of antimony, which I was led to prescribe upon pure inference as to its value as a medicine, based upon the well-known value of antimony and its salts, *i.e.*, the tartrate and arseniate. From the combination of iodine with antimony, it appeared to me a substance must result of greater value in chest inflammations than its relatives named. Clinical experience seems to corroborate in some degree this hypothesis. Iodide of antimony has proven as efficient in its sphere as the tartrate is in the relief of bronchitis of the finer bronchial tubes, or the arseniate in the pneumonias, especially of the aged, with feeble heart and extensive bronchitis and dyspnoea, or in certain cases of bronchitis associated with emphysema. A summing up of the experience thus far gained suggests its value in simple croupous pneumonia. The greater the cough and expectoration, the more prompt its action seems to be. In the intercurrent pneumonias, and especially in the occasional severe attacks of bronchitis occurring in the course of phthisis, its favorable influence is most conspicuous. We all know how often our cases of chronic catarrhal phthisis break down with what is called a cold, and how the usual cough becomes aggravated and the expectoration increases and becomes muco-purulent, and how, attending these symptoms, there may be chill, a remitting or intermitting form of fever, sweats, and rapid failure in flesh and strength. This is the condition which is generally benefited by our medicine.

In certain troublesome cases the remedy may be assisted as follows: If the cough is very troublesome at first, a little codeina may be given until it becomes less irritating. If the sweats are troublesome, a dose or two of agaricin may be given in the evening. If fever is excessive, a few doses of acetanilide will often assist in moderating it. By this method of helping the medicine in the control of cer-

tain annoying symptoms, most excellent results may be secured. Many well-known colleagues will be able to present cases corroborative of my experience in the use of this new and valuable medicine.

Agaricin, which received some attention in the lecture referred to, is a candidate for fresh honors. I treated of it chiefly in its relation to nocturnal sweating. I find that it is now recommended by several authors for this symptom, but not apparently with much confidence. With abundant experience, I claim that we have no remedy which is as reliable in its action, as permanent in its influence, or as free from unpleasant effects. This statement is based upon a large number of cases, many of which have been reported to me. Old-school practitioners seem inclined to combine it with other drugs.

About eighteen months since I was called to see a lady of 68 years, suffering from a severe attack of acute bronchitis. She had been my patient for many years. Latterly, I had treated her much for cardiac weakness, due to a degenerated heart, in turn consecutive to extensive pulmonary emphysema. She also had an enormous goitre. At her best, her respiration was labored and wheezing, and slight exertion caused great embarrassment of this function. After two weeks' care of this lady, her condition was most distressing; cough was troublesome, breathing labored, noisy, and the chest was filled with moist râles. The expectoration was tenacious and very difficult to expectorate. Coughing spells were followed by alarming spells of heart failure. The pulse now was irregular and intermittent. Each clearly appreciable beat was followed by one scarcely perceptible; then an intermission. The patient became semi-comatose, wandered, and had profuse sweats. Aside from medicines for the bronchitis, I gave, after the heart condition failed to yield to seemingly indicated remedies, digitalis, the same combined with nitro-glycerine; also strophanthi, sulphate of sparteine, and alcohol, but without any improvement. The sweats now being very profuse and debilitating for so weak a patient, I gave agaricin 1x tritr. grs. ij. hourly, and omitted all other medicine but whiskey. Six hours later the pulse was found greatly improved and the sweats much less. By evening the heart was beating regularly; every beat easily counted. Being surprised at this apparent result from the action of the agaricin, I stopped the medicine and gave placebo. Before morning the attendants had to resort to the "extra powders for the pulse," with the result of my finding only some disturbance of rhythm and an occasional intermission upon my early morning visit. Again I stopped the medicine, and by 2 o'clock the pulse was almost as de-

fective as at the worst. Again I gave full doses, and by night the pulse was regular and fairly good in volume. Being satisfied from this test as to the agency of the medicine in improving the strength of the heart, I continued the agaricin regularly, and the patient made a slow but uninterrupted recovery from her acute troubles.

I have met several cases less striking than the above, but yet fairly evidencing the power of agaricin to stimulate a failing heart. I reported a case illustrative of this influence of agaricin in the *HAHNEMANNIAN* for December, 1892. This case was under the care of Dr. Norton during the latter portion of his illness. Dr. Northrup has promised to assist me in carrying out some experiments upon animals, in order to determine its physiological action more exactly, and I fully expect that such experimentation will corroborate this clinical experience.

Some months since Dr. Myers called my attention to the value of *equisetum* as a remedy for nocturnal enuresis, stating that he had treated several cases successfully. Having had two cases on hand for about four and six years respectively, and treatment not having been attended by any substantial benefit, I decided to make use of it.

CASE I. was a boy, æt. 13 years, who came under my care when he was seven years old, and whom I have treated intermittingly ever since. He has regularly each night saturated his bed, with rare exception, since he was a baby. Had given many remedies, performed circumcision, and applied a variety of "methods" with almost no result. There was no incontinence during the day. *Equis. ʒ* gtt. x three times daily arrested his disease at once. During the first three weeks of trial a mishap occurred only twice. During the next three weeks it occurred five times, but four were after his medicine had given out. The past month he has had 15 to 20 drops of *ʒ* three times daily, and has had only two errors. While this boy is not cured, it must be confessed he is making great strides toward a favorable result.

The second case is that of a little girl seven years of age, who has, like the boy, had incontinence since babyhood, but, unlike him, her trouble has been diurnal as well as nocturnal. Most days she wet herself two or three times daily. She is a very nervous child; indeed, has positive hysteria, indicated by the *globus hystericus*, and a wide range of hysterical symptoms. At times there has been a little improvement from remedies, but never any marked change until I gave her valerianate of ammonia, in grain doses, four times daily.

This remedy not only helped her hysterical condition, but she would go a week without any mishap during the day, and miss perhaps every other night. After a time it failed to accomplish anything, and I gave it up after varying the dose considerably. *Equisetum* θ gtt. v., three times daily, arrested the whole trouble immediately; not a single mishap occurred, day or night, for a week. Since that time the child has occasionally wet herself, both at night and during the day, but the errors have been rare. Such cases are interesting for many reasons aside from the therapeutic ones. Much has been said of the contraction of the bladder incident to this condition, and yet here are cases which have continued for years to empty their bladders frequently during the day and night, and yet are able at once, upon the administration of a drug, to hold their urine all night. I have used *equisetum* only in the tincture.

A few years since an English observer—if I mistake not it was Jonathan Hutchinson—made use of the biniodide of mercury dissolved in a watery solution of iodide of potash. It was claimed by a number of the most eminent English physicians that this preparation was much more active in the treatment of syphilis, skin affection, etc., than the unaltered biniodide. The combine revels in the name of the iodo-hydrargarate of potassium. The plan of preparation I adopt is to add grs. x of each to \mathfrak{z} of alcohol. The result is a slightly greenish liquid, which deposits a slight dark sediment. The solution should be filtered.

For several years it has been my custom to give this preparation in preference to the biniodide of mercury, and I believe with more satisfactory results. Unless there are the best of reasons for administering another medicine, I give iodo. from the incipency of scarlatina up to the time of desquamation. Its influence in the control of fever, tissue changes in the pharynx, communicating mucous cavities, and the glandular system, is more decided far than that of any other medicine I have used. Most cases are controlled promptly, and the troublesome features of this disease reduced to the minimum. During the first two days 5 drops of this tincture may be given every three hours in a \mathfrak{zss} water. If the early symptoms are well checked gtt. iij. may now be given, or even less, to be increased if special symptoms demand. Those calling specially for more frequent or larger doses are associated with the throat lesion. Early, *acon.*, *ben.*, or *gel.*; later, *rhus.*, *apis.*, or *arum t.* may be associated with it. If nephritis develops in spite of the continued use of iodo., it is perhaps best to omit it. Whether this drug acts in scarlatina as a germicide or sim-

ply as a homœopathic remedy, I am not able to decide. To the simple clinician it matters not.

I have now called attention to the unusual uses of a few medicines and to the uses of some which are seldom, or not at all, employed by the profession at large. I will not weary you longer, but say that my work in therapeutics during the past ten years has been aimed in the direction of simplification. My belief is that the period of amplification has passed. Our *Materia Medica* has grown so bulky that no man can know but a small portion of it (and fortunately that is all that is worth knowing). We need accurate clinical observation of the treatment of diseases. We have heard too much of what a remedy has done for given cases. Our literature is full of such cases. They are helpful, and it was the proper way to begin; but we must now generalize more—begin a process of contraction, a crystallization of our therapeutic knowledge. Unless we do so we must pity our posterity, unless each feels, to say with our funny citizen, “What has my posterity done for me?”

HOW THE APPENDIX DISAPPEARS.

BY SYDNEY F. WILCOX, M.D., NEW YORK.

(Read before the New York County Homœopathic Medical Society, June 8, 1893.)

ON March 16th of this year I was called to Mt. Vernon, N. Y., by Dr. Nathan Nutting to see, and, if necessary, to operate on a young man of 16 years of age, the history of whose case the doctor has kindly given me as follows:

“On March 2d I was called to see M. I. Found him vomiting frequently and freely. Vomited matter bilious in character. This was considered gastric, as I had attended him two or three years ago in a similar attack.

“March 3d.—Found him much better, but after seeing him he had a severe chill. He rallied after a time and got gradually better, and in a few days returned to school. He continued to complain of pain in the right hypogastrium, which was attributed to the effort at vomiting, as it was very violent.

“March 9th.—Was so much better that he visited the gymnasium and exercised quite violently.

"March 10th and 11th. Began to feel worse, and on

"March 12th.—Found him in bed, still complaining of pain and tenderness, with a temperature of 100. Remained about the same until

"March 15th.—In the evening, found him with a temperature of 103 and vomiting freely. The vomiting continued, and the morning of

"March 16th.—Found the temperature the same, and a well-defined tumor in the right hypogastrium. Then advised that Dr. Wilcox be sent for."

When I first saw him, about a half an hour before the operation, his temperature was 104, pulse below 100, full and strong. He had a slimy diarrhoea, the passages at times being involuntary, and he vomited at intervals. He lay on his back with the limbs extended. There was distinct swelling and tumefaction in the right iliac region, with dulness on percussion, and great sensitiveness to point pressure about an inch below "McBurney's point." I decided to operate at once, as his condition seemed perilous.

As soon as anæsthesia was complete, an oblique incision was made running down over the point of the greatest sensitiveness. The indurated mass was raised and drawn gently forward, when suddenly a gush of foetid pus came to the surface. This was kept from entering the general peritoneal cavity by turning the patient on his side and packing around with bichloride gauze.

The pus, as before remarked, had a decidedly fæcal odor, and a small fæcal concretion, the size of a kernel of wheat, floated out with it. The cavity was gently washed out with a warm bichloride solution, and the parts carefully examined for the diseased appendix, and then I obtained an explanation of what had always before been a puzzle to me. The appendix was easily found but ruptured, the torn and shreddy edges of the ruptured tube giving an appearance as though an explosion had taken place. The shreds were gray and gangrenous. The rupture had taken place through the posterior wall, splitting the appendix wide open. The anterior wall was intact, though greatly inflamed, and was attached by firm adhesions to the mass of agglutinated intestines. The groove, which constituted all that remained of the lumen of the appendix, was easily distinguishable with its mucous lining intact.

In attempting to follow up and find the opening into the cæcum I found it firmly closed, so I concluded to leave well enough alone, as there was no evidence of fistula remaining. The gangrenous

shreds were cut away with the scissors. Two silver sutures were placed in either end of the external wound to lessen its extent, the cavity was thoroughly packed with iodoform gauze in such a way that the diseased part was thoroughly isolated from the rest of the abdominal contents, and the wound dressed in the usual manner.

Since the operation the progress of the recovery has been uninterrupted, and at the last report the patient was practically well.

In accounting for the disappearance of the ruptured appendix, it is usually stated that it becomes absorbed, but this explanation has never been satisfactory. It is easy to suppose that a portion of the appendix may slough or ulcerate, but how the whole organ could be absorbed in a comparatively short time, I have never been able to understand.

It seems to me that the case which I have related offers an explanation for the disappearance of the appendix, namely, during the acute inflammatory period the appendix becomes glued to or into the surrounding mass of structures, and when the rupture takes place, this portion of the gut is split more or less its whole length. This allows it to flatten out on the mass of agglutinated intestines, the torn edges lose their sharp contour, and thus a flat strip of tissue instead of a tube remains and becomes unrecognizable as an appendix.

In this short article I have carefully refrained from the consideration of doubtful cases. I am considering simply cases of true appendicitis, and endeavoring to show it may happen in such true cases that the appendix may entirely lose its identity and fail to be found on careful examination, and I think I was unusually fortunate in catching this case *in transit*, and in being able to satisfactorily demonstrate the truth of my theory as to how the appendix may disappear.

TREATMENT OF CONSTIPATION AND SOME AFFECTIONS OF THE LARGE INTESTINES BY INJECTIONS OF OLIVE OIL.—Dr. Fleiner distinguishes two forms of constipation: atonic and spastic. The atonic is due to insufficient peristalsis and to contraction of long sections of the large intestine in nervous persons. In spastic constipation, massage, purgatives and faradization are useless and injurious. In both forms copious injections of olive oil are of service. Place the patient on his back, elevate the pelvis and inject from 400–500 cubic centimeters of olive oil. To prevent exciting immediate peristalsis warm the oil and inject slowly and cautiously. Use a fountain syringe with a long and olive tipped point, of the size of one's finger. Fifteen to twenty minutes will be requisite to do this injection. Inject every day for several days in succession. Generally, on the second to the third day, an action will be observed, when the quantity of oil may be reduced. This method is of use in fecal stagnation, especially with irritation, colic, typhlitis, ulcers of any kind. In constipation from mechanical compression of any source it is indicated. It is best to give the injection before going to bed.—*Wiener Med. Presse*, No. 13, 1893.

INAUGURAL ADDRESS ON SURGERY.

BY WILLIAM B. VAN LENNEP, A.M., M.D.,

(Chairman of the Surgical Section of the World's Congress of Homœopathic Physicians and Surgeons.)

THE instructions of the Executive Committee were that the chairmen should give a review of the literature of their respective departments for the past *year or two*. Such a review of the surgical work, if any justice were done to the subject, would require more time than the utmost limits of courtesy could accord even a chairman. We were also instructed to give the utmost possible latitude to the discussion of the various papers, and, as far as possible, to have the latter of such a character as to invite comment. The essays were, therefore, to deal with live subjects, to be suggestive, and not too exhaustive. To further this end a number of gentlemen have prepared themselves to discuss or, better, to enlarge the scope covered by the different essays. In this way, practically two or three papers are assured on each subject, which is viewed from as many different standpoints. Surgery in general will be the theme of an address to the Congress by our eminent colleague, Dr. Hel-muth, who will undoubtedly handle it as he only can. Again, the essays presented by the bureau cover a number of the most important divisions of the domain of surgery—anæsthesia, shock, the brain, the thorax, the bladder. Each of them will necessarily review the literature more or less completely.

It has, therefore, been deemed advisable by your chairman, for the sake of brevity, and particularly with a view of eliciting discussion, to confine himself to a subject that has not been touched upon by the members of the bureau—a review of the work done in the surgery of the intestines during the past year.

The aids to intestinal suture inaugurated by the work of Senn have been extensively used and modified in this country. In England, the decalcified bone plates were popularized mainly by the work of Jessett, but on the Continent, and particularly in Germany, these devices were looked upon with suspicion, and, after considerable discussion and experience, there seems to be a revulsion of feeling, until the ideal method is getting to be one that depends on the un-aided suture. This is particularly true of lateral anastomosis, which has come to stay apparently, the great drawback to plates and rings

of any kind being the small communicating opening, which in time contracts to a dangerous extent. To avoid this a four-inch anastomotic opening seems indispensable, and the technique is as follows:

The intestinal surfaces are united by two parallel rows of continuous Lembert sutures, a quarter of an inch apart and an inch longer than the proposed opening. The ends of the threads are left attached to their needles. The bowel is opened to the extent of four inches, a quarter inch from the two rows of sutures. Bleeding points are clamped until caught up by a whip stitch running around the opening and including all the intestinal coats. The two rows of continuous sutures first applied are then carried around this and the union is complete (Abbè). Weir and Markoe report successful cases by this method.

To avoid the danger of infection from opening the gut an anastomosis in two *tempos* has been proposed, the second, however, being carried out by nature. While intended particularly for gastro-enterostomy, the principle is applicable to any portion of the intestinal canal. The serous surfaces being united by a linear suture, an oval piece is cut out from each intestine, a quarter of an inch from the suture, leaving the mucosa intact. The free edges of this opening are united on one side, the bulging mucous membranes are drawn out, and a ligature tied tightly around them. The remaining free edges of the opening are then stitched, and the field of operation enclosed by a continuation of the first serous suture. By sloughing of the ligated mucous membrane the anastomosis is completed by the third or fourth day (Postnikow).

The importance of the firm fibrous submucosa as an anchoring ground for any suture is to be particularly borne in mind, and practice will teach the surgeon to recognize the resistance that shows it has been entered. While it is indispensable to the firmness of a suture that it should include a few fibres of this coat, great care must also be exercised not to perforate it and enter the intestinal lumen, as fatal leakage would result (Halstead).

Another valuable principle, which has a great range of applicability, *e.g.*, pyloric excisions, gastro-enterostomy, intussusception, end-to-end union, high rectal excisions, etc., consists of tacking together the lumina to be united by two stitches, one being applied at the mesenteric junction when that is to be included. An opening is made in the bowel a short distance from the ends to be united, which are then invaginated and drawn out of this opening by traction on the two sutures above mentioned. By passing a dozen or more in-

interrupted stitches through the tube that is thus drawn out, picking them up in the middle and dividing and tying them, the intestinal edges may be united at twice as many points. The sutured gut is then drawn back and the temporary opening closed. In this manner all the sutures are passed from the inside (Maunsell). A case of intussusception with carcinoma has been successfully treated by this method (Hartley).

A somewhat similar procedure has been practiced for irreducible intussusceptions. The intussusceptum and intussusciens are united at a point where the former enters the latter, by a fine silk suture which includes the mesentery. The intussusciens is opened two inches below this point, and the intussusceptum amputated. The stump is sewed with a whip stitch, arresting all bleeding, and the opening closed (Barker).

Another modification consists of amputation of the intussusceptum in the same manner, ligature *en masse* of the stump, and an anastomosis between the intestine above and the opening made to get at the intussusceptum (Bier).

The principle of the Heineke-Miculicz method of pyloroplasty has been extended to intestinal constrictions of a cicatricial nature in which resection is not deemed necessary (Péan, Hacker).

The danger of leakage after intestinal perforation or suture has been shown, experimentally, to be obviated by closing the opening or protecting the suture, by covering it with a neighboring loop of intestine or omentum. This has been found safer, and, of course, of wider applicability than the omental grafts so extensively used of late (Chaput). The same writer closed openings made in the intestines of dogs with five or six thicknesses of iodoform gauze in the shape of pads, the edges of which were stitched around the orifice. The gauze acted temporarily, working its way gradually into the bowel, the opening being closed by adhesions to neighboring coils of intestine or omentum. He also found that strips of iodoform gauze were an efficient protective to any intestinal suture.

It has also been shown, experimentally, that a part of the small intestine could be transplanted between two ends of the colon and replace the latter when extensive resections of it have been made (Micholi, Robinson). These experiments have led to a novel proposition for the treatment of the hitherto rebellious cicatricial strictures of the rectum. The patient is placed in the Trendelenburg position and the abdomen opened. A loop of small intestine lying near the rectum is removed, care being taken that a large nutrient

artery supplies each extremity of the piece to be transplanted. The ends are anastomosed with the rectum, forming a new channel around the stricture. The serous surfaces are scarified and sutured together. Subsequently this line of union is divided by compression forceps from the anus, cutting through one-half of the stricture, and making the two lumina into one (Bacon).

In resections for malignant disease, while one of several cases may be cited, in which the cæcum, ascending colon, and several inches of the ileum were successfully removed (Lowson), the tendency is toward an operation in several stages: 1. The growth is first isolated by resection, the two ends of the intestine being drawn out of the wound. 2. The continuity of the intestinal canal is established by anastomosis or end-to-end union. 3. The isolated growth is excised (Bloch, Hochenegg). This method can often be practised when hitherto we only had physiological exclusion by anastomosis at our disposal; it is a curative instead of a mere palliative measure, where primary excision is unsafe.

Among the substitutes for the bone plates may be mentioned plates of raw potatoes (Dawbarn) and raw Swedish turnip (Von Baracz). They have the advantage of being obtainable in emergencies, and can be cut to any size desired, so as to insure a large anastomotic opening. The sutures are fastened by being drawn through rubber tabs cut from drainage-tubing, much as carpet tacks are armed or protected (J. E. James).

Another device, which has excited considerable comment, consists of two metallic buttons or cup-shaped discs from the middle of which protrude hollow cylinders. One cylinder can be pushed into the other, but has to be unscrewed when withdrawn. The intestinal openings are drawn over the edges of the discs by a puckering continuous suture, and are firmly held together by them until union takes place (Murphy). Their sphere appears to be particularly end-to-end union, for, when used in a case of ileo-colostomy, the anastomotic opening closed to a dangerous extent in a few weeks (Keen).

The stomach has received considerable attention. Gastrostomy appears to be particularly indicated in cicatrical narrowing of the œsophagus, when tubage fails, as it offers a curative inducement in the shape of retrograde dilatation. For malignant disease it is dangerous and prolongs life but a short time (Senn). The rectus muscle and the eighth intercostal space are the points of election for the fistula. In the former location leakage is prevented by a sphincter-like action (Allingham). Leakage may also be avoided by the use

of two inflatable rubber bags, one inside and one outside, connected by a rubber tube. The operation is done in two *tempos*. It is claimed that the movements of the stomach are seriously interfered with, and considerable stagnation occurs; also, in all probability, the hepatic function is impaired if not destroyed, nutrition being carried on by the intestine (Ewald).

Gastro-enterostomy has been quite extensively practiced, with not altogether satisfactory results. It is, after all, but a palliative measure, and owes its popularity largely to the dangers of pylorotomy. With a view to lessen these, it has been combined with excision and closure of the openings in the stomach and duodenum.

Another palliative plan has been suggested, *i.e.*, jejunostomy. The jejunum, a short distance below the duodenum, is drawn out and divided, and the distal end sewed into the wound, while the proximal end is implanted into the distal intestine, a few inches from the fistula, to allow the pancreatic juice and bile to flow into the intestine. (Maydl).

Digital divulsion (Loreta) has resulted fatally from rupture, although not carried to the extent recommended by its originator (Swain).

Pyloroplasty (Heineke-Miculicz) has been successfully practiced a number of times for cicatricial pyloric stenosis (Page, Kochler, etc.).

A novel plan has been followed for the relief of dilatation of the stomach, *i.e.*, folding or plaiting its walls by rows of sutures which do not include the mucous membrane (Weir).

It is a generally acknowledged fact, that an operation for bowel obstruction is not completed until the intestinal paresis is relieved by puncture of the distended intestine. As a substitute for this, lavage of the stomach is proposed, and has been successfully used. (Lund).

Post-operative obstructions have been, in several instances, successfully operated by section and separation of adhesions (Lucas-Championnière). From the fact that these are soft, and easily separated within the first few days, the attempt has been made to break them up, by first washing out the stomach, and then pouring into the tube a half-ounce of castor-oil. Flatus and copious stools were passed (Klotz). Both lavage and opium are looked upon as dangerous from their masking effects in intestinal obstruction, although the former is of value immediately before an operation to relieve reversed peristalsis, and prevent actual "drowning" of the patient (C. M. Thomas).

Early operations or exploratory section, as soon as the diagnosis of obstruction is made, have been, more than ever, emphasized. The term "exploratory" is used because the pathognomonic symptom being fæcal vomiting, this should not be waited for, but the section made "on suspicion." Every condition, aside from fæcal impaction, which can produce the clinical picture, calls for a like treatment.

In cases where the cause of the obstruction is hard to find, a short circuit by lateral anastomosis has given gratifying results (Atkinson). Unnecessary, and often fatal delay and handling of the intestine is avoided in this manner.

Nelaton's enterostomy has also been resorted to in desperate cases. A rapid method of forming the artificial anus consists of attaching the intestine to the parietal peritonæum by eight or ten hæmostats, which are removed in twenty-four hours, when adhesions will have formed (Chaput).

In spite of the fact that the respective advocates of the clamp and cautery, and those of the ligature, in the treatment of hæmorrhoids, have partly ceased their invective against the more surgical methods of excision (Pratt and Whitehead), and directed their abuse to those who dare suggest any but the operation they have recently learned, colotomy, nevertheless, the excisions of malignant rectal neoplasm have increased their hold on the profession. And justly, too, for every physician should strive after curative rather than palliative measures. The plan proposed by Kraske has, with certain modifications, been extensively and successfully practiced and advocated (McCosh). The results are as satisfactory as could be expected with cancerous disease. The sphere of the operation has been extended to attack the uterine adnexa (Montgomery) and the terminal portion of the ureter (Cabot).

In consequence of the incontinence frequently resulting, to allow of more extensive enucleation, and to insure an asepsis of the wound, the writer has successfully practiced the followed method:

1. The formation of a permanent anus by inguinal colotomy, the intestine being drawn well down to leave an abundance of sigmoid flexure below, and to prevent prolapse.
2. Complete and thorough extirpation through the anus, through the sacrum, or by opening the peritonæum and drawing down the gut. Usually two or all three of these steps have been combined.
3. Closure of the resulting wound by granulation aided by suture.

In cases where the growth is not readily accessible from the abdomen or through the sacrum, Maunsell suggests the use of the prin-

ciple already referred to: the abdomen is opened and the peritonæum around the bowel incised. The growth is then drawn out of the dilated or incised anus by invaginating the gut. It is excised by amputating the intussuseptum and the stump sutured in the manner already described. The intestine is drawn back into the abdomen, and the peritoneal incision closed.

Inguinal colotomy or colostomy or sigmoidostomy is the operation of election and has been very extensively used to the exclusion of the lumbar, the well-known methods of suspension with a rod or suture, together with previous drawing down of the intestine being followed. When no time is to be lost the gut has been simply suspended with a rod, the wound being stuffed with gauze (Reeves after Maydl). When immediate opening is necessary a tube has been introduced and the bowel tied around it (Jones), or the intestine has been punctured with a trocar and a rubber drain attached to the canula to carry off the discharges (Robson). In this way contamination is prevented until safe adhesions take place.

The subject of appendicitis has naturally received considerable attention. While but little that is new has been published, what is already known has been emphasized, and, better still, the profession generally have been aroused to realize the importance of this affection. The impossibility of an idiopathic peritonitis, the frequency of appendical trouble, its fatality, and the importance of a study of each case from its incipency, by the surgeon as well as the physician, are becoming pretty generally realized. It was a healthy sign of the times to the writer when he offended the physician and disappointed the family by advising against an operation between attacks in a recent case. The advisability of such operations between attacks has been very strongly emphasized, and the cases, which were but few and far between when the writer gave his experience on the subject at the last congress, have been indefinitely multiplied, and have shown most satisfactory results (Morris and others). The indications are frequency of recurrence, increasing severity of attacks, and, particularly, continuance of pain and tumor between attacks. Persistent colicky pains, with tenderness in the region of the appendix, have been relieved by excision of the organ, which was found to be moderately diseased. Distinct attacks were absent (Hochsteter). The writer has opened three such cases, and has been surprised at (1) the slight changes in the appendix; (2) the suffering resulting from such lesions, amounting at times to complete invalidism; (3) the complete and permanent relief following excision.

Such cases have led to the use of the term "appendicular colic" (Binnie, Kammerer), which probably applies to the majority that get well, the pain being due, it is said, to expulsive efforts on the part of the organ to get rid of concretions, or to overcome stricture or twists. The indications for operation are the same, however, as when marked pathological changes are present, so that the distinction has but little clinical value.

While almost every case of so-called *typhlitis* is dependent upon a diseased appendix, an occasional report is published of lesions in the cæcum, which produce much the same phenomena and results. In one instance a circumscribed fæcal abscess was found to be due to a perforating cæcal ulcer. The onset of the trouble was more insidious, diarrhoea having preceded it and being present; the initial vomiting was also absent; the appendix was normal (Hartley).

As to the pathology of appendical disease, catarrh beginning at the cæcal junction is still considered the usual cause. This is followed by the well-known changes: thickening, stricture, ulceration, perforation, or the formation of fæcal concretions (Kümmel). Foreign bodies are rare, although occasionally met with (Pinnock). Tubercular disease has also been known to be a not infrequent cause of this affection (Delorme), and actinomycosis may also affect the organ (Lang).

The importance of early operating has received due attention, some going so far as to recommend it as soon as a diagnosis is made (Hurd, Marshall). Persistence or aggravation of the symptoms after twenty-four hours, and particularly, the characteristic signs of peritoneal infection are the indications mainly relied on. An occasional cure after septic peritonitis has been lighted up, gives encouragement to try to save life even in this desperate condition.

Cocaine as an anæsthetic (Tachard), and rectal puncture without anæsthesia have been resorted to in very weak patients (Richardson).

That attacks which subside should be watched with care and suspicion is shown by a case of the writer's: a young man got over a severe attack so completely that he was allowed to go about the house. A little exertion was followed by dangerous constitutional symptoms and the rapid development of a large tumor. A small, well-encysted abscess had ruptured, and the whole right side of the abdomen was filled with a stinking fluid only feebly protected by adhesions. But for these adhesions he would have quickly died of fulminating septic peritonitis.

As to the technique, iodoform gauze to protect the general ab-

inal cavity, together with a light pack of the same and a drain for the abscess, are universally used. The appendix unless readily accessible is usually left alone in these abscesses. Occasional cases of peritoneal infection have been met with in which the appendix was not perforated or gangrenous (Poncet).

Operations for the radical cure of hernia have been performed frequently, and on the whole, with improved results, but the tendency is a revolution from the enthusiasm that has led to indiscriminate operating and early reports of so-called cures by new methods. The ultimate results of a number of procedures have been reported, which show the failures, particularly after the method that claims to substitute a cicatrix for a truss (McBurney), and which has been extensively practiced (Bull).

The tendency now seems to be toward a restoration of the normal relations of the tissues as laid down in the method of Bassini. The principles of this procedure are, excision of the sac with obliteration of the peritoneal dimple, closure of the internal and external rings, and narrowing the canal, which has been split, by a close approximation of the different muscles and fascia. The narrowing of the external ring has been still further completed by chiselling a groove in the pubic bone, laying the cord in this, and covering it with periosteum which has been preserved (Frank).

The presence of the cord as an invitation to recurrence has been studied too. Its removal to prevent relapse once led to such a universal practice of castration as to call for special legislation. The sac being excised and sutured or tied, the ends of the ligature are passed through the muscles above the internal ring to draw up and smooth the peritonæum. (In this connection it is worthy to note that Tait's proposition, to reduce the hernia and close the sac and ring from the inside through an abdominal incision, has been practised occasionally.) The cord is hooked up while the muscles and fascia are closely united, obliterating the inguinal canal; by fastening the cord in the outer angle of the wound, its direction of exit is changed from that of the inguinal canal to directly forward, or forward and outward. It is then laid outside the muscles, and the skin and fat closed over it (Halstead). By carrying an incision upward from the internal ring the direction of the cord may also be changed to an upward one, whence it comes down into the scrotum as above (Fowler). To lessen the size of the opening all but one or two of the spermatic veins, which are apt to be enlarged, are excised (Halstead).

As aids to closure of the opening decalcified bone has been used:

also the outer pillar of the external ring has been detached, together with a bit of bone forming its insertion, carried across to the inner pillar and nailed to the symphysis. In this way the opening is reduced to a mere slit (Landerer). The sac has also been used as an external plug in contradistinction to Macewen's internal pad; after being isolated it is drawn out of an opening opposite or external to the inner ring thus changing its direction. It is then twisted to obliterate the peritoneal dimple (after Ball), and fastened outside of the aponeurosis of the external oblique (Kocher).

Following the observation that the mesentery of the protruded gut is usually lengthened in hernia, and that the presence of this condition invites recurrence, it has been proposed that it be shortened by folding and suture (Shimwell).

To avoid infection of the wound, particularly in children, the urine has been diverted through a peritoneal opening (Gerster).

The treatment of femoral hernia, hitherto either entirely ignored or relegated to a hurried postscript after an elaborate description of a new method for the cure of inguinal hernia, has received more attention.

The stump of the sac may be tacked well up inside the abdominal wall through which the suture ends are passed, or the isolated sac may be drawn through an opening above Poupart's ligament, twisted and incorporated in the lower wound, serving in this way as a plug to fill the femoral canal (Kocher). The need of such a plug or barrier has led to the turning up of a piece of the fascia of the pectineus muscle where it is thick and tough (Salzer), or the fascia and a flap of this muscle itself (Cheyne). In this manner the femoral canal is completely closed.

As the results of operations for the cure of inguinal hernia have been far superior to those for the femoral variety, an attempt has been made to transform the latter into the former. The tumor is incised and the sac freed; the inguinal canal is split and its posterior wall divided; the sac is drawn into this opening, tied off, and both wounds accurately sutured (Ruggi).

• The indications for an attempt at radical cure are (1) ineffectual, partially effectual, or painful trusses; (2) irreducible hernia; (3) occupation tending to force out the rupture; (4) proposed occupation which is precluded by hernia; (5) strangulated hernia, where the local and general condition permit of such an undertaking (Bennett). Hernia in women, particularly when young, with the child-bearing age before them, seem to merit a trial of operation (Lucas-Championnière).

he treatment of gangrenous or suspicious bowel still calls forth a diversity of opinion. Relief of the constriction, warm applications, or temporary replacement with an anchor thread attached should be tried in all uncertain cases. If a doubt still remains, the intestine is fastened outside the abdomen, dressed warmly and antiseptically, and observed. In a case in which this plan was followed the gut was found normal on the fourth day and successfully replaced (Rovsing). In similar cases it is suggested that the gut be well drawn out, an anastomosis made above the suspicious area, and, after sloughing has taken place, the two openings be closed and the gut replaced (Helferich).

In general, however, primary resection is to be preferred to the formation of an artificial anus, and gives, on the whole, a lower mortality. It is of course understood that the patient's condition and the surroundings permit such a procedure, and that the surgeon has the requisite skill.

As to the method of uniting the two ends, the weight of opinion seems to be in favor of the end-to-end plan, with or without aids. These artificial aids may be in the shape of rubber rings or splints, or metallic buttons to hold the ends together; a rubber tube or decalcified bone drains to hold the intestine open and prevent invagination. When the two lumina are unequal, several plans may be followed: lateral anastomosis, lateral implantation (the small end into the side of the large tube), slitting up the smaller tube, or excising a V-shaped piece from the larger on the surface opposite the mesentery until the openings are of equal size, when they are united.

The dangers of the persistent use of taxis have received well merited attention (Bennett). Bruising or rupture of the bowel are often produced and much valuable time is lost. These two factors are largely responsible for the mortality of from thirty-two to forty-six per cent. in the large English hospitals (Southam). The local application of ether, followed by gentle and intelligent taxis for not more than five minutes, and that only when a true hernial impulse is perceptible, will obviate the above mentioned dangers. Immediate recourse to operation after the failure of such procedures cannot be too strongly emphasized. The persistent application of sulphuric ether to strangulated hernia has brought about reduction when taxis, under an anæsthetic, has failed (Finkelstein). Such a procedure would be particularly useful as a preliminary to taxis and operation before the arrival of the surgeon and during the preparations for operation.

Although, as a rule, the presence of an undescended testicle in a hernial sac calls for castration, Depage records a case in which it was drawn down into the scrotum and the hernia treated in the ordinary way.

Cases of strangulation symptoms from the appendix, omentum, and testicle are also reported.

Of the special varieties of hernia, a number have been published :

1. Littrè's hernia with no tumor, the partial nipping of the bowel in the right femoral ring being found and reduced through a median abdominal incision (Keen).

2. An obturator hernia, strangulated and made out by a tumor, was successfully operated by Wyman. Anderson opened the abdomen for persistence of obstructive symptoms after an operation for femoral hernia, and found a knuckle of gut in the left obturator foramen. Examination by the rectum or vagina, as well as the diffuse deep swelling and pain, are the diagnostic points (Berger).

3. Ischiatic hernia has also been found : (a) through an abdominal section after persistence of symptoms in spite of a femoral herniotomy (Garve); (b) on removing a fibro-lipoma, to which two hernial sacs were found attached (Schwab).

4. Hernia into the foramen of Winslow was made out, but not reduced by abdominal section, recovery following a large enema (Neve).

5. Diaphragmatic hernia has been met with, but only diagnosed after death.

6. Pro-peritoneal hernia has been looked for and found, on account of non-relief of symptoms and difficulty in reduction (Bull and others).

7. The writer has operated two cases of hernia of the urinary bladder recently. Pain was a prominent symptom, but vesical symptoms were absent. No truss could be worn. In one the attenuated diverticulum was opened for the sac, the bladder drained, and the wound allowed to heal by granulation. In the other the viscus was recognized and the abdominal wound treated in the ordinary way. Both recovered and have not had relapses so far. The subject has received considerable attention (Aue, Lélars).

PÆONIA is useful for fissures of the anus, with much oozing, keeping the anus damp and disagreeable all the time. This is associated with great soreness and smarting.

NEVER DARE!!

BY GEORGE B. PECK, M.D., PROVIDENCE, R. I.

HOLLOA, Doctor, don't you dare to do that again! "Who are you talking to, anyway?" You, Hahnemanniac, mongrel, purist, impurist, alternationist, low-dilutionist, high-dilutionist, or whatever else you may style yourself, or be dubbed by others! You, I mean, who practice at all homœopathically, whether believing in *similia similibus* as the *only* law of cure, or, simply as the best hitherto discovered, or merely as a good working rule for general or occasional use. You, who prescribe at any time, or at all times, according to that formula, with forethought and deliberation, *you* are just the person I am talking to now! Don't you dare to do it! "Dare to do what?" Don't you dare to go to bed again—"Not dare to go to bed again! What *shall* I do? Sit up all the time?" Hold on there! Don't interrupt! Listen! Don't you dare to go to bed again until you have willed your medical library to some *public* library or other public institution! Do you *hear*? Furthermore, don't you dare to send another periodical, or another volume of homœopathic literature, to the junk dealer, or even to the second-hand bookseller! "Whew! What's got into you, now! Do you want to impoverish me and ruin my family?" Tut! Tut! You don't know what you are talking about! Did you ever see a fellow pay for his harness repairs, much less for carriage repairs, by the sale of professional literature? Drop, then, all pecuniary consideration of this matter, it is too picayunish! "But why should I do thusly?" Look here! Are you an honest man or aren't you? If you're not, pass on! I'll not trouble you farther. If you are, your reputation is of some value to you; your reputation, while living, when you *can* defend yourself, your reputation after death when you *can't* defend yourself; your reputation as an honest man, I mean.

Now, you know, as well as I, that it has been the policy of the *regulars*, from the advent of the new school to date, to vilify everything pertaining to homœopathy, to asperse the motives of its adherents, to misrepresent their acts, and to appropriate, stealthily, their discoveries. You know, also, that the old school is possessed of large libraries, wherein are carefully preserved *its* histories of *all* *heresies*, and that it so controls most public institutions as to prevent the purchase of all books that bear not the stamp of its approval.

You know, or ought to know, that, according to the current historic method, every alleged fact stands or falls as it is established or disproved by *contemporaneous testimony*, printed, documental, or monumental; also, that the life of any book begins only when it finds a home on the shelves of some permanent organization. Hence, if you are not anxious to have your name descend to posterity blackened with charges of hypocrisy, deceit, and fraud, of ignorance, malice, and malpractice, you will, at once, make provision for the deposit, on the shelves of some convenient literary or scientific institution, of all periodicals now stacked in boxes or barrels in your attic, and all unused volumes (early editions, perchance) lying on the floor of some dusty closet. There would be no objection to your binding the magazines neatly, but inexpensively, before presenting them; they would make a finer show; but, if your resources are limited, most librarians will gladly relieve you of that burden in order to secure their possession. Regarding other books, there can, of course be no question. Dispose thus, *at once of all things* in your professional library that you are not likely to use—they will immediately commence a life of greater activity and usefulness than that they have hitherto enjoyed; they will be eloquent witnesses that the corresponding codicil of your will was written with soundness of mind and deliberate intention, and, if that clause, then the entire will also. Should you desire, occasionally, to refer to a volume, the privilege would be readily and cordially granted. There can, then, be no valid objection to each one's commencing this good work at once, unless a desire to boast of the extent of one's bookshelves be so rated. Having definitely decided what must be the character of my future professional work, I have already placed upon the shelves of the Brown University Library all homœopathic works that could not be strictly included in my working library (toward one hundred and fifty volumes), and I shall contribute volume after volume, as I may cease to require it for immediate reference. I cannot too strongly urge each brother and each sister in his (her) own abiding city, town, or village, to do likewise. The varied benefits of such a course must be apparent to all.

“But what has set you going at this rate all of a sudden?” If you'll keep mum, I'll tell you. Not such a great while ago I chanced to be in a friend's office, when he remarked that he had complete files of all the leading homœopathic magazines for some thirty years, but he didn't know as they would ever be of any particular use to him. Inherent modesty prevented my offering sug-

gestions at the time, but his words so burned in my brain that a few weeks later I called again, and diffidently suggested his presenting them to one of three libraries, two of which I knew would most gladly receive and care for them. Imagine the chagrin and disgust which overwhelmed me when he replied, "Why, if I had thought they were of value to anybody I would gladly have given them to you, but they went more than a fortnight ago to the junk-dealer!" Kick me! I soliloquized, but did not ejaculate, for he weighs fifty pounds more than I do, and his boot is proportionately large. I have never ceased, however, to kick and prod myself for my senseless remissness. Do you wonder I am rather sore on this subject, and am very anxious to retrieve, as far as possible, the evil effects of this one of countless blunders in life.

Just one word more, Doctor, before we part. A few years ago, an accomplished, and therefore studious, physician died, leaving a valuable library. Among other treasures, was a file of a rare serial publication suitably bound. At the public sale of his effects it brought the enormous sum of *four cents a volume*. Fortunately, it now rests where its worth is appreciated, and will be utilized, but *no thanks are due the decedent*. You had better throw your library, for the sake of saving three cents a volume to your heirs (the fourth will go for expense) to an ignorant *horde of auction rounders*, and deprive yourself, for that paltry sum, of the satisfaction and the honor of inestimably benefiting your fellow-citizens, your school and your profession.

SOME OBSERVATIONS CONCERNING THE CLINICAL SIGNIFICANCE OF HÆMOPTYSIS.

BY EDWARD R. SNADER, M.D., PHILADELPHIA.

(Read before the Oxford Medical Club.)

THE occurrence of blood-spitting is looked upon by the laity as an appalling accident. It is fortunate that the public mind views hæmoptysis in the light of a grave and threatening danger, inasmuch, as while the occurrence of blood-spitting is not always indicative of a serious lung disease, the hæmoptysis has that significance so frequently that the laity should realize that the exact gravity of the symptom must be determined by the physician. The determination of the gravity of this symptom is not by any manner of means an easy task in some instances.

While it is true that hæmoptysis is, in the vast majority of cases, dependent upon a consumptive lung lesion, the error is to be avoided of considering all hæmoptyses of a certain color as having their origin in organic changes in the pulmonary textures.

Structural changes in the heart, and more especially valvular and orificial lesions, account for a larger number of cases of blood-spitting than is ordinarily appreciated by the medical profession. Certain it is that many physicians regard a copious hæmorrhage as of necessity arising *per se* from a specific lung lesion, and totally disregard the cardiac apparatus as a strong producing factor in ordinary lung bleeding. It is true a hæmorrhage is the result of lung lesion, but a structural change resulting from a break in vessel or tissue continuity from mechanical blood pressure is essentially different in prognostic significance compared with bleeding from an area of organically affected by a process practically "consumptive." In some heart hæmorrhages, too, it is possible that no actual rupture of pulmonary tissue occurs; tissue-stretching and diapedesis may permit of considerable bleeding.

In general, aside from the two principal causes of hæmoptysis (the pulmonary and cardiac), numerous other lesions and conditions along the respiratory, œsophageal, gastric and gastro-enteric tracts, occasionally give rise to this symptom.

The determination of the exact origin of an hæmoptysis is, in some cases, one of the most difficult problems of practical diagnosis. Assuming the correctness of a history of bleeding from the mouth, the solution of the question of causation cannot be definitely ascertained save by the most elaborate examination of the heart and lungs. Sometimes an obvious local condition along the respiratory tract may produce slight or considerable hæmorrhage, and yet one cannot feel certain that the heart or lungs were not the cause of it. Unless one sees himself a bleeding surface, he cannot be certain that the blood did not have another and possibly more serious origin. Conditions capable of producing bleeding may be found, and yet bleeding may really not have occurred as a consequence. In other words, unless one is sure of the soundness of the heart and lungs, he cannot feel positive of the exact origin and significance of the bleeding.

If an examination of the heart and lungs shows that they, by reason of normality, are incapable of participating in the production of hæmoptysis, then, by exclusion, we conclude that a given discoverable local lesion is alone and exclusively blamable for the hæmoptysis.

Local changes in the tissues of the nasal tract, sometimes obviously

enough, account for this symptom, as hypertrophic catarrh (particularly when acute), post-nasal adenoid vegetations, polypi, traumatism and the hæmophillic diathesis occasionally lead to blood-spitting, the patient not being able to determine, by reason of inattention or ignorance, whence the blood originated.

The pharynx, when œdematous from acute or chronic, local or general, systemic disease (as scarlatina, etc.), sometimes permits of the expectoration of blood-streaked mucus, and, not infrequently, of what I may call pin-pointed bleedings; that is, the sputa are dotted here and there with minute blood-points.

The buccal cavity is responsible for a fair share of blood-spitting. The gums, particularly, and hollow teeth occasionally, have accounted for quite a number of cases of blood-spitting sent me for examination by their physicians, who feared, from the persistence of the symptom, some grave pulmonary disorder. Patients having a decided red line along the gums—and their number is legion—have a special tendency to be subjects of “gum hæmorrhage.” This latter occurs, too, when scorbutis is not present. Aphthous mouths, and those suffering from cancrim oris, sometimes have bleedings. Certain forms of glossitis cause the symptom, as well as other local conditions of the tongue, under rare circumstances.

Aside from the obvious bleeding that takes place when a tonsil bursts from the suppurative process, I have seen several cases of what I diagnosed herpetic tonsillitis, in which the entire pharynx and buccal vault and gums were intensely engorged with blood, in which blood-spitting occurred.

A fresh catarrhal laryngitis with considerable œdema is sometimes the origin of blood-streaked sputa, and decided hæmorrhage has occurred from a rupture of vessels within the voice-box.

Now, many of these instances are sufficiently obvious, but, aside from congestion of the lungs, acute catarrhal pneumonia, acute miliary tuberculosis, pulmonary œdema, croupous bronchitis, gangrene and abscess of the lungs, acute emphysema and sometimes even in croupous pneumonia, the occurrence of fairly free bleeding, is mightily suggestive of some serious lung lesion, as one of the forms of phthisis pulmonalis, or malignant pulmonary disease, or of some cardiac malady or aneurism of the aorta. While it is possible that vicarious menstruation has occurred through the lungs, I have never personally seen a case in which hæmorrhage occurred at the time the menstrual period should occur in which I did not find a readily demonstrable lung lesion.

The occurrence of blood-streaked sputa in ordinary bronchitis is far more frequent than is believed by the profession at large. Formerly I viewed blood-streaked mucus coming from the chest as of great significance, and thought it indicative of some incipient lung involvement.

In the heart and lung department of the Hahnemann College I made it a rule for a long period of time to examine minutely all patients who mentioned this symptom and from whom by questioning I could elicit it. I was surprised, however, at the number of cases in which this symptom occurred in which the minutest physical exploration failed to discover the presence of lung lesions. I was surprised, too, on the other hand, to find many cases who complained of this bloody mucus in whom was discovered considerable areas of lung solidification without the usual typical symptoms. The investigation of these cases for supposed lung disease was a revelation to me, therefore, in two ways: first, as to the frequency with which blood-streaked sputa occurred without lung lesion, and, secondly, the frequent latency of lung lesions, so far as the production of the ordinary symptoms of lung malady was concerned. I am never sure of the significance of this symptom when bronchitis is present without a careful exploration of the chest. It is true that the symptom of itself is due to the lesions incident to a bronchitis, but without examination I am uncertain whether the bronchitis is idiopathic or secondary to some change in the lung structure, latent or not.

Blood-spitting occurs from the stomach, and is not always characterized by vomiting, sometimes simply by a gulp, as if the mouth were full of liquid. Indeed, while this fact is a matter of observation, hæmorrhage from the lungs is not infrequently characterized by vomiting, and because a phthisical patient feels sick at stomach he will declare he vomited the liquid. One cannot always be certain, unless present at the time of the onset of the hæmorrhage, whether the blood was really vomited or expectorated. In acts of vomiting of blood from the stomach the impact of the fluid against the pharynx often provokes cough, and associated cough, therefore, does not help to a solution of the problem of origin. We cannot depend too much upon the concomitance of cough or the presence or absence of vomiting to decide whether the blood be from a pulmonary or gastric source.

Congestion of the stomach from valvular heart disease, certain forms of gastric catarrh, cirrhosis of the liver, carcinoma of the stomach and liver, and other less obvious conditions may give rise to

hæmorrhage from the stomach. I need not mention gastric ulcer, which characteristically gives rise to hæmorrhage, according to the books, but, according to my personal experience, is sometimes present without hæmorrhage.

Little dependence can be placed upon the color of the blood in determining its origin. Blood dark in color frequently comes from the lungs, and that, too, when the hæmorrhage is very large (big branch of the pulmonary artery) or when it is very small. Sometimes a hæmorrhage takes place slowly enough to be decolorized. Long retention will change it. I have seen, too, cases of dark blood from a gastric ulcer. The color depends upon the character of the vessel eroded and the rapidity with which it is poured out. The "copper grounds" vomit in some cases of carcinoma is not coffee grounds at all, but fairly profuse and bright red. I have noted bright red hæmorrhages in one case of cirrhosis of the liver.

Air bubbles, when many in number, are very suggestive of pulmonary hæmorrhage, but are by no means pathognomonic, inasmuch as blood, while passing through the throat and mouth, may imprison enough air to give rise to the bubbles. Some pulmonary bleedings have no air bubbles whatever. I have seen solid liver-like lumps ejected.

The acidity or alkalinity of blood from below the diaphragm is dependent upon the condition of the stomach and whether the bleeding occurs during the digestive act or not.

If I shall have enforced care in pronouncing upon the significance of blood vomited or expectorated, and that, too, only after a careful consideration of all the possible factors, I shall be satisfied that the lesson of this paper has been learned.

A STUDY OF PAINS IN THE STOMACH IMPROVED BY EATING.—Dr. Taube finds this symptom to be of varying significance. In rare cases of round ulcer of the stomach the pain disappears when food is taken. Warm or hot milk will ameliorate on account of their warmth. This symptom is relatively rare in the provings. v. Bœnninghausen gives the following as improved by eating: iodide of sodium, bov., cann., chel., ferr., ignat., lanoceras., phosphor., sabadilla and strontia. This symptom is generally observed in neuroses of the stomach, though it may be seen under other states. Hence ignat. will be of service though in the pathogenesis nothing is said of an amelioration after eating. It is also an accompaniment of chronic gastric catarrh, dyspepsia, ulcer of the stomach and other grave stomach diseases, as well as in median abdominal hernias. He finds ars., nux vom., rhus tox. and *lycopod.*, as the most serviceable and especially *lycop.* and *nux vom.* as pre-eminent. In cases with this symptom one should be carefully examined for a median ventral hernia, for even a very small one without contents, may be the cause of serious trouble. It may be even as small as a cherry and involve only the adipose tissue.—*Zeitschrift Des Vereines Berliner Hom, Ärzte*, XI. Bd., Hft. II.

CYST OF THE BLADDER.

BY JOHN E. JAMES, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

THIS case is reported because of its rarity, as I find no record of a similar case.

Mr. K——, æt. 54, rather sedentary life, pale, emaciated, and weak,—has suffered for years with short breathing and at times with difficult respiration due to a chronic bronchial catarrh. About five years ago began with trouble with his urine, dribbling and inability to retain it long; this was followed by frequent attacks of retention, requiring use of catheter, burning pain on urinating, pain at meatus and in glans penis, stream interrupted and after change of position would flow again. These symptoms gradually increased until about five months before operation, since which time has always used catheter for voiding urine. Upon examination found in the bladder a rounded mass which seemed to be on the left side and could not be felt per rectum. While all the symptoms except bloody urine and the click of the sound pointed to stone, the diagnosis of probable tumor was made and an operation recommended. He was prepared in usual way and the bladder opened by the supra-pubic route; upon introducing the finger a tumor about the size of an average sized English walnut, soft and fluctuating, was found located a little above and to right of the mouth of the urethra so that it acted as a float-valve of a water tank does, allowing some urine to pass and then would drop and close the outlet. Upon spreading the sides of incision it could be distinctly seen, a cyst of the bladder wall with rather a broad base. It was ruptured and the sac entirely removed; hæmorrhage, which was rather free, soon stopped and wound was left open to heal by granulation. His recovery was slow but uneventful, temperature about normal except for two or three days of the second week when an attack of rheumatism of the right hip and thigh caused it to rise to 102° as the highest point. He went home in about five weeks with still a small opening in the bladder which was rapidly closing.

ACNE OF YOUNG PEOPLE.—*Kali brom.*, *berb. aq.*, and *psorinum* have been my best remedies. Two or three cases in which the acne was worse at the menstrual period, *engenia jambos* relieved.

ARGENTUM NITRICUM SUCCESSFULLY USED IN A CASE OF PSEUDO-MEMBRANOUS ENTERITIS.

BY FRANK H. PRITCHARD, M.D., NORWALK, OHIO.

A CASE of this relatively rare affection coming under my notice, I take the liberty to report it, as it brings to notice a remedy which, though theoretically adapted to the cure of this disease, yet I cannot, in the limited literature at my disposal, find a record of its having been used successfully in this state. P. S. Wales, in his article on this disease, in Pepper's *System of Medicine*, mentions it as of great value in local treatment. I. T. Dana also recommends it locally in the article on this affection in the *Reference Hand-book of the Medical Sciences*, vol. iv., p. 190.

Dr. W. E. Gill, of Norwalk, Ohio, who treated the case, gave me the following outlines: A young girl of 7 years, fleshy, fair, and bright, with a clear complexion, had previously been in good health and attended school regularly. Her parents were healthy, if one except that the father was slightly inclined to asthma. She was of a quick and active temperament, and of a long-lived family. In November, 1892, she was seized with the disease and treated by another homœopath for several months without success. When Dr. Gill was called in he found her apparently well and in good health, except that every day, at irregular intervals, she would suddenly be seized with a pain in her abdomen, and with a drawn face, as if expecting the painful attack, cry out, "It's coming on now," lie down upon the sofa or floor, cry, turn and twist to ease the pain. These seizures would appear at irregular times either day or night. Her bowels were nearly normal, with alternating periods of slight diarrhoea or constipation. She would pass much gas both per anum et orem without relief. Her appetite was good. At the time of the attack there would be slight vesical tenesmus, while she was peevish, and with a drawn look around her mouth as if expecting pain; tongue not coated. On examination of the abdomen it was sore to the touch, especially in the region of the descending colon; no bloody stools, though at the time of passing the characteristic ribbon-like bands, which greatly resembled a tapeworm without the segmentation, she was inclined to a watery diarrhoea. These were discharged every three to four days, with great abdominal pain and distress. They were of a whitish appearance and of a muco-fibrinous con-

sistency. After giving several remedies in vain, *argentum nitricum* 6x was administered during the first week, one tablet of the trituration every three hours. That week she was much improved; she had no more pronounced "spells," but now and then mere indications of them. The next week she received one tablet once a day, and then that following week one every two days. At the end of a month she was entirely free from her painful seizures, and has for three months since remained so. At present she is well and hearty, runs, plays, and attends school regularly.

Dr. James R. Cocke, of Boston, Mass. (*New Engl. Med. Gazette*, 1892), records a case of this same affection which was successfully treated with *mercurius corr.*, chiefly with the occasional intervention of *nux vomica* and *colocynthis*, and, as adjuvants, massage of the abdomen, electricity, and a restricted diet. A cure was obtained. *Mercurius corrosivus* is also employed, though topically, in this morbid condition, by the old school. The successful remedy would, in my mind, necessarily be one which would be chosen with regard to the basic pathological condition, *i.e.*, the exudative enteritis rather than to the pain element alone, and from such a class as that including the nitrate of silver, corrosive sublimate, the bichromate of potash, etc., which present croupous conditions, for, though it is hinted to be of nervous origin, and the low inflammatory process a result, yet the latest authorities state, in substance, like Roche long ago did, in the *Dictionnaire de Médecine et de Chirurgie Pratiques*, vol. vii., p. 311, Paris, 1831: "L'histoire de cette maladie est encore à faire. . . . On ignore quelles en sont les causes, si toutefois elle en a des spéciales."

OBITUARY.

DR. F. KAFKA.

DR. F. KAFKA, one of the most eminent physicians of Austria, died at Prague on the 30th of April, 1893. Having studied at the Universities of Prague and Vienna he took his degree as physician at Vienna in 1836, and began his practice at Metnik, a little town in Austria, where he remained until the year 1846, when he removed from this town to Prague. There he remained until his death.

Before his settlement in Prague he visited once more the University of Vienna, which at this time was at its height. He soon enjoyed a large clientele, which grew from year to year and made him one of the most famous physicians in Prague.

About 1850 Prague was visited by a most violent croup epidemic, against which the physicians then were almost powerless. By accident one of his former fellow-students, Dr. Lury from Brünn, passed through Prague, and he introduced Dr. Kafka into the science of homœopathy. He told him some of the remedies which he had used in his own family against croup, and Kafka began the study of homœopathy, which resulted in happy discoveries for humanity. His first work, *From the Practice*, he first published in the *Monthly Review* of Altschul at Prague, then in Dr. Kirschd's *Neue Zeitschrift für Homoöpathische Klinik*. Finally he became a regular contributor to the *Allgemeine Homöopathische Zeitung* at Leipzig, and all his publications are distinguished by a prominent spirit of observation and knowledge of remedies. In 1857 he drew general attention by his controversy with the editor of the leading allopathic journal, the *Vienna Medical Weekly Review*.

It was the year 1865 which brought the first volume of his great work, *Homœopathic Therapeutics Founded Upon the Physiological School*, which was published in 1869 and was edited by Empel at Sondershausen. It is this work which made the name of Kafka famous.

From 1871 to 1876 Kafka was the editor of the *Allgemeine Homöopathische Zeitung* in Leipzig; however he then was induced to give it up, as it was desirable that the editor of this review should have his residence in Germany.

Kafka's high standing in the medical world was generally acknowledged in life and in death, his name will always be honorably mentioned as one of those who have rendered great and lasting services to the good cause of homœopathy. He leaves a son who at Carlsbad follows the footsteps of his great father, whose memory he honors by devoting himself to the same great cause.

H. ELB, M.D.

DRESDEN, May 16, 1893.

ECZEMA AT THE MENSTRUAL PERIOD.—At every month eczema would appear about the genitals and inside of thighs. *Petrol.* 6 relieved, and on return of the trouble *petrol.* 30 completed the cure.

EDITORIAL.

THE WORLD'S CONGRESS OF HOMŒOPATHIC PHYSICIANS AND SURGEONS.

CHICAGO fulfilled her promises. The indefatigable work of Drs. Mitchell, Ludlam, Smith and Dunn, together with the earnest support of the Chicago profession, resulted in bringing together the largest number of homœopathic physicians the world has ever seen. One thousand earnest and able advocates of the new school of medicine thoroughly imbued with the responsibility and possibility of the exceptional opportunity to place homœopathy in its true light before the world, in convention met, bringing with them the best thought of the world upon the therapeutical reformation. This reformation, which has stood the test of time, now passes on to the future in triumph. Its adherents have multiplied from 5000 in 1876, the time of the first world's congress, to 12,000 of to-day. It has invaded the citadel of the enemy, even to its fireside, stamping the impress of homœopathy upon every page of its therapeutics. It is to be hoped that a result of this congress will be to assist the medical world to a better understanding and to a true conception of homœopathy, and as its aims are revealed to the blinded, the spirit of prejudice and persecution will yield to calm investigation and full acceptance of the truth for truth's sake, rendering impossible the repetition of the sorry spectacle of an English Earnest Hart traveling thousands of miles, abusing hospitality, by trying to coerce the liberal and tolerant element of the so-called regular school of medicine in America into not consulting with homœopaths. A scientific physician, no matter what his school may be called, accepts truth wherever it is found and manfully acknowledges its source. The majority of allopathic therapeutical writers have still to do the manful act.

The sessions of the American Institute of Homœopathy were short, practical and to the point, and many changes have been made which will vastly improve the workings of the Institute and infuse the crispness of new life. The Bureaus are reduced in number and increased in membership. The designation "bureau" is changed to "section." The Bureau of Anatomy has been dropped and Pathology becomes part of Clinical Medicine; Mental and Nerv-

ous Diseases takes the broader designation of Section of Neurology. The chairmen are not limited in the number of their associates, excepting that there must be at least five. The most important change made and the one that will renew the vitality of the great organization is the removal of the time limitation of the sessions of the sections. They can now have all the time they want. This means the development of the scientific side of the sessions, and will appeal strongly to the enthusiasm of the younger element of the school. This is a large, earnest and willing branch of the profession, and it would be to the advantage of the Institute to secure their interest in its business affairs, but it will not be accomplished until some rule is adopted to choke off those few martyrs to the cause who jump up to speak to every resolution, sometimes two or three times, pouring out a perfect deluge of words, and supplying an astonishing paucity of ideas. Forbearance has long ceased to be a virtue in this line. The absurd fashion of calling upon delegates for reports of their local institutions and societies has also been abandoned. These important changes in the by-laws show a brilliant advance in the line of correct organization, and the members of the Institute are deeply grateful to the active workers present at this meeting for having given such splendid evidence of their level-headedness.

Denver, Colorado, secured the session of 1894 by an overwhelming vote. While we have no objections to Denver as a place of meeting, we do consider it a bad policy to keep the Institute either east or west two years in succession. The meetings should be held east of Chicago every other year. The coming year being the fiftieth year of the Institute the selection of Boston, Mass., as the place of meeting would have been peculiarly appropriate. The queen city of Colorado won, and the HAHNEMANNIAN will do its best to assist in making the semi-centennial jubilee a great success. The Chicago meeting, however, is going to be a difficult one to surpass.

THE MEDICAL EXAMINERS' BILL IN PENNSYLVANIA.

ON Friday, May 19th, 1893, the Governor of Pennsylvania signed a bill which will go into effect March 1st, 1894, establishing a *Medical Council of Pennsylvania*, consisting of the Lieutenant-Governor, the Attorney-General, the Secretary of Internal Affairs, the Superintendent of Public Instruction, the President of the State Board of Health and the presidents of three separate boards of medical ex-

aminers to be appointed for the State of Pennsylvania—one representing the Homœopathic Medical Society of the State of Pennsylvania, one representing the Allopathic Medical Society of the State of Pennsylvania and one representing the Eclectic Medical Society of the State of Pennsylvania, each board to consist of seven members, the Governor to appoint the members respectively from lists of the members of the said medical societies on January 1st, 1894.

The bill is the result of a compromise effected after a meeting of the schools before the Judiciary General Committee in Harrisburg, February 14, 1893. The Old-School committee represented the idea of majority *control* of medical licensure in the State, and the Homœopathic committee stood for fair play, by assuring exact and equal justice for all schools of medicine, in demanding a separate and distinct board for each school.

The Old-School physicians made a splendid fight in a bad cause and met an opposition—with a righteous cause—too vigorous to be overcome, and found that no fair-minded, unprejudiced man was willing to subject the weaker schools to a majority allopathic control. The question then resolved itself into “three boards or none,” and the situation became a test of the sincerity of the Allopaths’ claim that they were actuated solely by a desire to conserve public interests by placing a check upon improperly qualified practitioners by means of a State examination and license. They wanted the controlling power and their rank and file expected their committee to secure it for their school. To have refused to grant equal rights and privileges to each of the three great schools of medicine in the State would have branded them with insincerity and would have supplied their opponents with an abundance of ammunition to carry on a winning fight. Their position was an unenviable one for them, but wise and conservative counsel prevailed, and as it was useless to contend against the inevitable, they accepted the situation. From that time out the committees of the three schools worked together harmoniously to perfect the details of the proposed new law and the result of their united effort will go into effect on and after March 1st, 1894.

SHALL HAHNEMANN'S “CHRONIC DISEASES” BE REPRINTED?

THE firm of Boericke & Tafel have issued a little circular under this heading with a subscription blank attached stating that there is a demand for a “reprinted” edition. They claim:

"To bring out such a work involves the expenditure of a goodly sum of money—a risky expense, that few publishers care to assume. Messrs. Boericke & Tafel have, however, determined to make the attempt to *reprint* this grand old work. Estimates have been obtained, the cost figured out, and now it only remains for the gentlemen of the homœopathic medical profession to indicate their wishes. If a sufficient number will subscribe to the undertaking to enable the publishers to see their way towards paying for paper and type-setting, the old book will again be obtainable; otherwise it will remain out of print.

"The only English edition of the *Chronic Diseases* ever published was issued in five small volumes, in 1845, and has been long since out of print. The proposal is to reprint that edition in one volume of a size uniform with the *Materia Medica Pura*—pages $9\frac{3}{4} \times 6\frac{1}{4}$ —on fine paper, and bound in half morocco. So printed it will make a solid volume of about 1200 pages. The price, delivered to subscribers, will be \$8 net."

As these publishers frankly state they will not take risks themselves—a condition all publishers assume in their ventures, we fail to appreciate, why they propose to ask the exorbitant price of \$8 for a one volume work of the cheapest kind of book-making—reprinting. But there is a more serious side to the question. Why foster upon the profession a *reprint* of Hempel's faulty, inaccurate, and far too liberal translation of the *Chronic Diseases*? Turning hap-hazard the pages of volume 1 of Hempel's translation, on page 19, we find Hempel speaks of "the venereal bubo," whereas the original is "Venerische Schanker-Krankheit"—venereal chancre. On page 37 in referring to the older writers Hempel has translated "Eiterbälge im Gekröse." "Sacculated bags full of pus in the intestines" whereas "abscesses of the mesentery or mesenteric abscesses would be more than an improvement." On page 40 appears "Diabetes (suppression of urine)—Morgagni." Diabetes is hardly an acceptable synonym for suppression of urine. Nor do we believe Hempel ever intended to convey such an idea. On turning to the original we find it is due to carelessness; here is given two references "Harnruhr (Diabetes) reported by C. Weber. Then a new paragraph commencing Harnunterdrückung—(suppression of urine)—Morgagni." On page 41 "Knochenfrass" is given "cancer of bones"—whereas it clearly refers to caries of the bones. "Knochen-Geschwulst des Knie's" is too liberally said to be "Osteo-Sarcoma of Knee." "Swelling of the bones of the knee" is the meaning evidently intended by Hahnemann, and so it runs on, page after page with wearisome repetition. Added to this the English translation

is so liberal and loose that Hahnemann's meaning is all but lost. When read in connection with the original the meaning and ideas of the author can be traced, but the laxity of the translator's work is, as Hering said on more than one occasion—horrible. We have been looking for a new and correct translation of the first volume of the *Chronic Diseases*, knowing that such a translation is well under way by one of our distinguished writers. To reprint the old edition of 1846 filled with its errors of omission and commission, would naturally be the death-knell of the new. Let the publishers display the true spirit of energy by bringing out a new and *correct* translation of Hahnemann's *Chronic Diseases* and the profession will gladly pay twice the real value of the work. Hempel's translation should certainly *not* be reprinted.

THE PROPOSED INCOME TAX.

THE secular press has teemed of late with editorial discussion of a proposed tax to be levied on individuals possessing an income of five thousand dollars per annum or over. The receipts from this source are designed by the projectors of the scheme to make up for the loss of revenue arising from a proposed reduction of the tariff. It is claimed that a tax imposed on individuals in possession of a good living income will not be a burden on more than ten per cent. of the population, whereas at present, the high tariffs impose an expense on the entire country, the high and the lowly alike. The proposed income tax would certainly bear directly on quite a number of physicians, not on all, it is true, probably not on as many as ten per cent., which it is believed it will affect of people in other occupations.

The income tax will be an unnecessary burden on the profession at first, and later, on their patients. Such a tax is particularly unjust to the profession. Physicians are the only men in the world who give their services freely to charity, to the needy. They do not hesitate to make reduced charges when the circumstances of the patient demand such a course, while the lawyer and the tradesman never thinks of so doing. The injustice is again apparent when the doctors' early privations are taken into consideration and the heavy family and social demands are weighed with the comparatively small income. A doctor in active practice has no time for outside ventures to make money. His services to the community in official positions and in hospitals and dispensaries take all his spare moments.

GLEANINGS.

GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D., AND FRANK H. PRITCHARD, M.D.

PAROXYSMAL TACHYCARDIA.—Dr. Rosenfeld finds often in this affection where the pulse may run up to 200 in frequency, the pulse will be imperceptible, and instead of the heart-beat, a sort of trembling in the præcordial region, that this state may be succeeded by slowness of the pulse, which persists for several days. The attack is terminated by emission of colorless urine, and the patient is well during the intervals. Often it appears in neurasthenia, hysteria, as an accompaniment of digestive or genital affections, in abuse of tobacco, or in anæmia, or exhausted individuals. It is a special neurosis disease and is due to paralysis of the inhibitory influence of the pneumogastric. Digitalis, nitroglycerine, the nitrite of amyle, etc., have a doubtful action. Compression of the vagus, in the cervical region, will sometimes shorten the attack.—*La Semaine Medicale*, No. 23, 1893.

INEQUALITY OF THE PUPILS.—Dr. A. Reche has studied a number of patients at the Breslau eye clinic, and comes to the conclusion that inequality of the pupils is not of so much importance as was formerly thought. Though neurologists have stated that it is a sign of serious cerebral disease he would say that, in every-day practice, it is of but very little moment.—*Medicinische Neuigkeiten*, No. 15, 1893.

DIAGNOSIS OF INCIPIENT EFFUSION INTO THE PERICARDIUM.—Dr. W. von Ebstein considers this subject chiefly from the point of view of percussion. In their incipency only, auscultatory sounds are nowadays relied upon. The writer claims that by means of percussion one is able to determine the presence of an effusion in the pericardiac sac. The relative dulness of the liver begins in the fourth intercostal space, on the right, and extends, somewhat weakened, into the fifth. With pericarditic effusion this dulness will be more distinct and pronounced. It will be the more distinct the more that portion of the lung which covers it is pushed back by the distended pericardium, which is dependent upon the increase of the exudate. Hence, as a rule, one may diagnosticate a pericardiac effusion by the presence of dulness in the right fifth intercostal space, at the border of the sternum. This sign is of value in hydro- and pyo-cardium but not in fibrinous pericarditis which is exceptional, in acute pericarditis. In hypertrophy of the heart it will be of service as a differential point, for in this affection, the heart rarely encroaches beyond the sternal border. Though it is not entirely certain it is safe to assume that a dulness that extends for three centimeters to the right of the sternum, in the fifth intercostal space, is due to an effusion into the pericardium, especially where it develops under one's eyes, and the adjacent portions of the pleura and lungs are normal. The pulmonary changes occupying this region are recognized by auscultation. A small and circumscribed pleuritic exudate would be difficult to diagnosticate.—*Norsk Magazin for Lægevidenskaben*, No. 4, 1893.

TREATMENT OF RODENT ULCER BY THE INTERNAL ADMINISTRATION OF ARSENIC.—Lassan presented a lady before the Berlin Medical Society with a rodent ulcer upon the bridge of the nose, which had been cured by the internal use of arsenic alone. Fowler's solution was both injected subcutaneously and given internally, with the result that within two months the entire ulcer had healed over. Instead of the deep and irregular-margined ulcer, its place was occupied by a flat, smooth and slightly-sunken cicatrix. The drug was continued a month longer after the healing was complete. The writer claims that by internal medication alone one is able to stop the spread of a malignant ulceration of this kind, to clean its surface and induce the regeneration of new integument without local treatment.—*Deutsche Medizinische Wochenschrift*.

DEEP INCISIONS IN ANASARCA.—Arnemann discusses the value of deep incisions into the subcutaneous tissues in general dropsy, and quotes a case where it was of the greatest benefit.

The patient, a man of 63 years of age, suffered for some years from Bright's disease—probably the contracting form. He had several times had great œdema of the legs, which was reduced by rest in bed, diuretics, etc. In the early part of 1889 he became water-logged, and in spite of various remedies was rapidly worse. He was cyanotic, with intense dyspnoea. The pulse was irregular; the urine in abeyance. Under these circumstances extensive incisions were made in the skin. They were carried right through the whole depth of the enormously œdematous skin, and each measured about one inch and a quarter in length. Serum began immediately to flow, and the patient to breathe better, and later on to lie down. The fluid flowed uninterruptedly in such quantity that repeated changes of towels were of little use. It ran through the bed on to the floor and into the neighboring room. The relief was very striking, an amendment beginning at once, and reminding one of the relief afforded when an empyema is evacuated. The procedure adopted in this instance with such success was to make a few incisions, not more than eight, but these were large, the skin and subcutaneous tissue being divided so that a free exit was provided for the pent up serum.—*The Practitioner*, April, 1893.

COCAINE IN THE APPLICATION OF ELECTRICITY.—Wrap a copper ball electrode with absorbent cotton soaked in a 10 per cent. solution of cocaine. The cocaine serves to relieve irritability of mucous membrane so often present, and even penetrates to some extent into the sub-adjacent tissues, exerting a calming effect upon their nerve tendrils. Fifteen to twenty, and sometimes less, milliamperes of galvanism will serve to further destroy the hypersensitive condition of the uterus and its adnexa.—O. B. Will, M.D., *Annals of Gynecology and Pædiatry*, 1893.

PRODOMATA OF ACUTE ARTICULAR RHEUMATISM.—Dr. A. Hock finds the prodromal phenomena of acute rheumatism to be dismissed with but brief consideration in the text-books. Yet, in the older works certain characteristic fever symptoms are described as preceding articular localization. All the writers on fever in rheumatism describe a fever that is either continuous or subcontinuous and which may assume the type of a typhoid, meningitis, or even hectic fever. The author has observed still another type.

A girl of 21 years was found unconscious, without any known cause; she soon came to and, in twenty-four hours, had another attack. At the hospital she was found in her full senses but with violent headache. Internal organs normal. Temperature, 38°; at 4 P.M., 39.2°; headache less; no other symptoms. The next day she felt completely well. Temperature, 37.2°. The following day, painfulness of the ankle-joint set in with lichen urticatus. Temperature, 37.8°. From then on a gradual and multiple acute articular rheumatism developed which ran a severe course, lasting two months. She left the hospital with a mitral insufficiency and slight sensitiveness of the joints. The author has also observed a second similar case. The peculiarity of this fever is that it resembles that of acute exanthems.—*Wiener Medizinische Presse*, No. 17, 1893.

A RARE FORM OF HEADACHE.—Professor Benedikt calls attention to a form of headache due to hyperæsthesia of the cranium, localized especially at the osseous suture. It is observed at all ages, and is especially due to excesses, and, above all, mental overwork; hence it being observed in students who are preparing for examination. It is also met with in certain nervous affections, as Basedow's disease. Sometimes, also, during the course of an attack of migraine, one will find an oversensitiveness of the corresponding portion of the cranium, it being especially pronounced at the occiput, mastoid process, orbital and palatal walls.—*La Semaine Médicale*, No. 14, 1893.

ALCOHOLIC CIRRHOSIS OF THE LIVER.—Dr. Hanot, of Paris, in a lecture at the Hôpital St. Antoine, reviews the subject of alcoholic cirrhosis. There is always a predisposition to the disease, a primordial cause with the organic modifications which it determines and intercurrent complications. The modes of termination are various. Arthritism predisposes. Arthritic subjects are liable to vulnerability of the connective tissue, to hyperplasia and fibrous retraction. The prodromal or pre-cirrhotic symptoms are: dyspepsia, meteorism, constipation, urobilinuria, a urobiluric tint of the integument, sometimes even a bronze-colored complexion, pigmen-

tary acholia, alimentary glycosuria, pruritus, epistaxis, hæmorrhage from the gums, local œdema and crises of diarrhœa. There is usually disgust for fatty foods and repugnance to meat with occasional bulimia. In biliary cirrhosis one often observes hyperchlorhydria, in atrophic cirrhosis. Hypopepsia, purpura, epistaxis, hæmorrhages from the gums, are all signs of the hematopoëtic system. Varices are frequent, hæmorrhoids. There are crises of diarrhœa alternating with constipation. Icterus is the last act, in the atrophic form of the disease. Death may occur before the affection has run its course from erysipelas, pneumonia or bronchopneumonia, infectious endocarditis, suppurative peritonitis, or cholecystitis, abscess of the liver, nephritis, phlebitis, etc. Sometimes they will perish with choleraic symptoms; profuse, grayish diarrhœa, alidity, coma, an infection due possibly to the bacterium cell.—*La Semaine Medicale*, No. 27, 1893.

MEDIASTINAL TUMOR WITH SUFFOCATIVE SYMPTOMS.—Dr. Lazarus had under his care a man of 51 years, who twenty-seven years ago contracted syphilis. Four years ago he was affected with hoarseness which developed into dyspnœa. He was somewhat emaciated, pale, had slight orthopnœa while in bed. Extensive pigmented spots on his body containing chalk-white patches. Nothing abnormal in the thoracic cavity except slight dulness of the left apex. By auscultation nothing could be determined, as a very loud strider from the larynx or trachea drowned all other sounds. Left of the sternum there was a slightly dull spot from the first to the third rib. Heart and abdominal organs normal. The larynx and mucous membrane was very pale, the left vocal cord immovable; a recurrent paralysis. This might be due to an 1. Aneurism. 2. From a mediastinal tumor, or 3. Infiltration of the apex of the lung and traction upon the nerve. It could not be an aneurism as the heart and vessels were normal and at the place of dulness there were no symptoms of such a tumor; tuberculosis was out of the question as the hoarseness had lasted for years and there was no ulcerations; it could not be a mediastinal carcinoma as the whole course and his appearance were against that. The cervical and epitrochlear glands and an inguinal gland were enlarged: syphilis. The iodide of potash improved his condition and for four or five weeks he was subjectively in absolutely good condition. He had a good appetite, slept well and his dyspnœa disappeared. The sternal dulness increased, went upon the right and he became worse and died in a month. The necropsy developed enlarged mediastinal glands and a stricture of the trachea at the level of the manubrium sterni which would scarcely permit the passage of the head of a pin. In the late forms of malignant syphilis the circumvallate papillæ of the tongue undergo atrophy and disappear, so that the mucous membrane lies directly upon the muscular tissue. Paralysis of the vocal cords is seen, regularly, in aneurism of the arch of the aorta, especially on the left side, with gradual atrophy and fatty degeneration of the cord which is remarkable from its characteristic yellow color. Small aneurisms may cause strider or suffocation and the patient perish without presenting any other symptom of an aneurism. Compression may reduce the trachea to a mere fissure. Anti-syphilitic treatment may also improve greatly the symptoms of aneurism, for they often stand in near relation to that disease.—*Deutsche Medicinische Wochenschrift*, No. 18, 1893.

CHRONIC MASTITIS IN A MAN.—Dr. W. Anderson records the case of a man who had an enlargement of the mammary gland two and a half inches in circumference which had attained this size in six months. It was removed and microscopically it presented the picture of a chronic fibrous mastitis. The writer compares it with the chronic mastitis of women during the menopause. Thus there is a complete correlation between mastitis in both sexes for mastitis neonatorum and that of puberty are well known.—*Norsk Magazin for Lægevidenskaben*, No. 3, 1893.

ACUTE SPLENIC LEUCÆMIA.—Prof. Eichhorst finds that though leucæmia as a rule appears as a chronic disease it also may assume an acute course. He finds twenty-six cases in the literature and contributes the twenty-seventh. An 8-year old boy twelve days before was seized with pains in the cardiac region and the same day frequently vomited a bloody fluid. He became pale and his abdomen rapidly increased in circumference. Had always been healthy and his family is robust. On entering the hospital slight fever, pulse 140 and arrhythmic. Skin affected but not œdematous, no sign of enlarged lymphatics. Some effusion into the pleuræ as well as slight ascites. Area of hepatic dulness increased to two centimeters be-

low the costal arch. Spleen enlarged and reaching from low in the abdomen up to the seventh intercostal space, in the axillary line. Urine normal. No appetite, no thirst. Blood corpuscles 114:1 (normal 400:1). No nucleated red corpuscles nor eosinophile leucocytes. Hæmoglobin reduced to 25 per cent. of the normal. No sensitiveness to pressure on the sternum nor femora. The following days he continued to grow steadily worse, his skin was cool, slightly swollen but not cedematous, pulse small, nearly imperceptible and rapid. Vomiting continuous and most frequently bloody. Yellowish, bilious diarrhœa set in which were partly mixed with blood. The temperature sank to two degrees below the normal, five days after his entrance. He died the same day with symptoms of collapse "like one bleeding to death."—*Virchow's Archiv.*, Bd. 130, S., 365.

HÆMOPTYSIS IN AORTIC ANEURISMS.—Dr. Smith has observed this symptom in several patients with aneurism of the aorta and he considers it a useful sign in the diagnostication of doubtful cases. A cough which is more or less distressing with bloody expectoration and accompanied with a sensation of anguish or pain in the chest when one can exclude cardiac, renal and pulmonary diseases, is a symptom of aortic aneurism. These same symptoms may also be due to mediastinal tumors.—*La Semaine Medicale*, No. 29, 1893.

TWO CASES OF OSTEOMALACIA.—Dr. Genersich describes two cases of this affection. The symptoms were: helplessness in every position, motion impossible, painfulness of the bones, atrophy of the muscles from inactivity, increased reflexes with completely intact sensation, and finally the characteristic pelvic anomalies. The bones had lost two-thirds of their lime, being so soft that skeleton could not be prepared.—*Wiener Medicinische Presse*, No. 18, 1893.

MUSICAL CARDIAC MURMURS AUDIBLE AT A DISTANCE.—Dr. J. Weiss demonstrated a case of musical cardiac murmur audible at a distance of a metre from the patient's chest, in a woman of 42 years, who, for a year, had suffered from severe cardiac asthma. The left ventricle was found enlarged, a systolic mitral murmur with a musical diastolic aortic murmur. These murmurs may be cardiac or pseudocardiac. The latter originate in the bronchia, in the intrathoracic venous channels, or, very rarely, in the pericardium. The cardiac are caused by pathological conditions in the left venous or the left arterial ostia. At the mitral valve endocarditic processes leave shrivelled and abnormally tense tendinous cords which produce sounds of a high timbre; congenital cords or those from atrophy of the trabiculæ carneæ may also cause them. Deposition of lime salts in the valvular ring may give a ringing and musical character. At the aortic valve they are due to highly calcified semilunar valves which project as stiff plates into that vessel, constricting bands, binding the noduli, the products of former inflammatory processes or cord-like remains of the semilunar valves are discovered as the cause of these sounds *in vivo*. The pericardiac musical murmurs appear with the associated symptoms of pericarditis. The explanation of these murmurs is often difficult. They are either due to a tense vibrating cord in the blood current or passage of the blood through a small slit or fissure.—*Wiener Medicinische Presse*, No. 16, 1893.

CARDIAC SYMPHYSIS.—Prof. Potain, of Paris, recently lectured on this state which is characterized by an adhesion of the two layers of the pericardium and its consequences. The adhesion may be more or less extensive, varying from a few fibrous bands to complete adhesion, of the whole membrane. The cavity is dilated and the walls increased in thickness; extension to the pericardium, pleura or mediastinum may help to fixate it by fibrous bands. Most cases are found from the fifteenth to the twentieth year. Though generally due to rheumatism it may also follow pneumonia, scarlatina, the majority of infectious diseases and tuberculosis. Tuberculosis of the pericardium is followed by complete adherence. The consequences of symphysis are: dilatation and hypertrophy. Dilatation is always found. Hypertrophy succeeds in the cases of total adhesion, the less complete forms are not necessarily associated with it though one-fifth is the number said to be affected. With fibrous bands there is a clacking sound to the right in the epigastrium, but when the symphysis is complete the heart is increased in volume, the thoracic wall is depressed or bulging, in some cases. A most important point is a non-changing of position of the heart whatever position the patient may occupy. Whether he lie upon the right or left side the apex beat remains unchanged. The second sound is doubled. This is also characteristic of mitral stenosis, but if the other signs are

lacking one may diagnosticate a cardiac symphysis. It is accompanied by a diastolic shock and a diastolic bruit de galop. Unfortunately these symptoms are none of them infallible, but if one have a case of cardiac hypertrophy, in a young subject, without orificial lesions and without signs of myocarditis one may think of cardiac symphysis. The prognosis is grave if the myocardium is affected deeply; if this be not degenerated the consequences are often slight. In apparently grave cases examine the nose, for the symptoms may be due to obstructions there which aggravate the symptoms. If the pulse be irregular and feeble the myocardium is also in the same state. When the hypertrophy is considerable, the prognosis is the most gloomy. Prophylactic treatment is of the greatest importance; avoid fatigue or violent efforts. Exercise is useful, fatigue is dangerous. Overeating is also fraught with danger. Digitalis, strophanthus and caffeine are indicated in arrhythmia. If the myocardium is degenerated beware of digitalis. Caffeine is then useful.—*La Semaine Medicale*, No. 30, 1893.

PRIMARY ACUTE POLYMYOSITIS.—Dr. Benno Lewy describes several cases of this disease. First there is a gradual beginning with gastric symptoms. In a few days there are noticed rheumatoid pains in various parts of the body, often of a spasmodic nature. The extremities become stiff and immovable, and the patients take to their bed; they lose their power over their muscles. The muscles of deglutition and respiration are usually affected. The muscles become sensitive to pressure and swell. The single muscles lose their form and the extremities assume a formidable appearance. The muscles may have a hard, tense or a soft and even fluctuating feel. In more chronic cases there are circumscribed muscular nodes. Hardly ever are all the portions of the body simultaneously affected. The extremities are more early implicated than the trunk. In long-continued cases distinct atrophy may be observed. Oedema of the neighboring muscles and skin occurs, the arms being more attacked than the legs. The hands are usually not at all involved while the greatest oedema is seen around the elbow joint, face and in the back. The skin over the affected places is reddened and often erysipelatous, with possible exanthemata as a roseola-like eruption, urticaria, subcutaneous hæmorrhages, etc. Inclination to sweat, violent stomatitis and angina, spleen increased in size, dysphagia and dyspnoea, fever of moderate height, pulse not increased much in frequency. It is to be differentiated from trichiniasis and multiple neuritis.—*Berliner Klin. Wochenschr.*, No. 18, 1893.

GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D.

ABORTIVE TREATMENT OF COLD ABSCESSSES.—Calot claims that cold abscesses can be cured in eight days by a thorough removal of all the diseased tissues and immediate closure of the wound. It matters not how extensive or old they are, if they only be accessible. In case immediate union is not obtained they are certain to recur or to leave a fistula. Immediate union can be obtained only under the following conditions:

1. The adjoined tissues must have a sufficient vitality. Hence it will not suffice, in all cases, to remove the wall of the abscess, but sometimes it will be necessary to go more deeply and to cut into the muscular tissue in order to have a vascular and vitalized surface.

2. All drainage must be omitted. The drain renders reinoculation of the tissue almost certain. It may also, even if aseptic, leave a fistula that will persist indefinitely.

3. The walls of the wound must be held in apposition both by sutures and compression so that not the slightest space is left between them.

This method is especially indicated in old and extensive cold abscesses. The writer has thus treated one which held over three quarts, and which resisted all other methods for nearly three years.—*Le Semaine Medicale*.

PENTAL.—Velez (*Rev. de Med. y Cir. Pract.*) has used pental as an anæsthetic in 108 cases with perfectly satisfactory results. In many cases where it was necessary to keep the patient anæsthetized for a considerable time, he was allowed to regain consciousness, and then once more placed under the influence of pental; in half a minute narcosis was complete. In one case pental was thus administered three times in thirty minutes, and two hours afterwards the patient, a man, æt. 28, was able to walk home, the only after-effect observed being excessive drowsiness during the remainder of the day. Velez thinks pental may with advantage replace chloroform and ether in many operations of short duration. Fifteen centigrammes given on a mask filled with coarse wool will induce narcosis in one minute. Instead of losing its effect, the drug seems to act better on the same individual at each successive application. The pulse is at first accelerated, but recovers its normal condition in a few seconds. During unconsciousness the patient sleeps quietly, the face retaining its natural color, and the eyes being open and fixed. In some cases insensibility is absolute, but, as a rule, consciousness is not altogether abolished. The patient awakes quietly, and no disagreeable after-effects are observed. Velez thinks that patients will take pental repeatedly without the slightest repugnance. Pental, being readily inflammable, should never be used at night.

THE ABORTIVE TREATMENT OF BUBO BY THE WIELANDER METHOD.—This method consists of an injection of fifteen minims of a 1 per cent. solution of the benzoate of mercury into the bubo, followed by compression. Wielander and Letnik succeeded in preventing suppuration in ninety per cent. of the cases treated.

Brouse (*Montpellier Med.*) tried this method in five cases, and succeeded in only one. There is always a more or less local reaction, and generally a systemic disturbance, characterized by headache, fever, loss of appetite, a general feeling of discomfort.

Ducamp accounts for this as follows: The mercuric salt diminishes the resistance of the cells, allowing the microbes to increase and secrete more freely their toxic products, which products, entering into the circulation, cause the systemic disturbances.—*L'Union Medicale*.

ELONGATION OF THE LIGAMENTUM PATELLÆ TREATED BY TRANSPLANTATION OF THE TUBERCLE OF THE TIBIA.—Walsham (*Lancet*) describes two cases of knee trouble dependent upon elongation of the ligamentum patellæ.

The first occurred in a young patient, 21 years old. She complained of pain and difficulty in walking, and that she was liable to fall suddenly, without warning, from the patella slipping over one or the other condyle. The falls were so frequent and unexpected that she was incapacitated for her duties as a housemaid. The patella could be dislocated laterally on either condyle, and with the knee bent at an angle of 90° it could be pushed up over the condyles of the femur, so that its anterior surface looked upward instead of forward. The elongated ligament was shortened by transplanting the tubercle of the tibia about one inch lower down the shaft. The wound healed by first intention, and when the patient was last seen the knee-joint appeared normal and the patella could no longer be dislocated laterally, nor pushed abnormally upward.

The second case was in all respects similar, and was treated in the same manner.

Walsham believes that transplantation of the tubercle of the tibia is to be preferred to the excision of a portion of the ligament and the subsequent union of the cut ends by sutures. He recently transplanted the posterior tubercle of the os calcis, with the tendo Achillis attached, for overcoming the elongation of the calf-muscles in paralytic talipes calcaneus.

INTRAVENOUS INFUSION OF ALCOHOL.—A man, suffering from strangulated right inguinal hernia, was operated on recently in St. Thomas's Hospital (London). He was in a state of extreme prostration; his general condition was most desperate. The carotid pulse (after the operation, which lasted only five or six minutes and was performed without an anæsthetic) was very feeble, the pupils dilated and each respiration seemed as if it would be the last. Three pints of warm sterilized normal saline solution were injected into the circulation through an opening in the basilic vein, each pint containing one ounce of brandy. The effect was remarkable. In ten minutes a good pulse could be felt at the wrist, the extremities were warm, the pupils and respiration normal, the voice strong, the face became red, and the patient so wide awake and excited that a quarter of a grain of morphia was injected to secure quiet.—*Lancet*.

TREATMENT OF NÆVI BY SUBLIMATE-COLLODION.—Cresfeld recommends the use of sublimate-collodion (one to eight) for vascular nœvi as a painless and rapid method of cure, one that acts with certainty and produces no disagreeable symptoms. The growth and a small portion of the surrounding skin are painted with a moderately thin coating of the collodion. This is blown upon until it dries, when the procedure is repeated once or twice according to the size of the growth. A protective dressing is then applied to prevent the collodion from being brushed or washed off. In about ten days the crust drops off, leaving a dry, white, smooth, superficial cicatrix. If any vascular tufts remain, the procedure is repeated until they have entirely disappeared. This method has been successfully applied to telangiectases of considerable size.—*Nertzlicher Praktiker*.

TREATMENT OF ANCIENT LUXATIONS OF THE HUMERUS.—Severeanu (Bucharès), in a case of dislocation of the humerus of four months' standing, after having employed powerful traction to no purpose, accomplished reduction by arthrotomy. The head of the bone was exposed by raising a triangular flap when traction again failed. A gouge was then passed behind the humeral head, by means of which it was easily lifted into the glenoid cavity. At the end of thirty days the patient was able to carry his hand to his mouth.

Pollosson has made use of this plan in five cases with satisfactory results. Ollier's incision between the pectoral and deltoid was used, the capsule opened and the head forced little by little, with the aid of traction, into its normal position. Considering the grave accidents which occasionally follow attempts at reduction, the bloody method appears to deserve a trial.—*La Tribune Médicale*.

PULSATING EXOPHTHALMOS TREATED BY DIRECT COMPRESSION.—Riequè reports the case of an old woman who had sustained a fracture of the base of the skull. A few days later there developed violent headache and symptoms of a phlegmon of the orbit with chemosis. Puncture gave exit to blood and some relief. Pulsation and a thrill were made out, and direct compression was tried, which was followed by marked improvement. Eight months later most of the symptoms were still absent.—*La Semaine Médicale*.

TO PREVENT EMPHYSEMA AFTER RUPTURE OF THE LUNG.—Bramann (*Berliner Medizinische Wochenschrift*) met with a case of enormous emphysema of the body after rupture of the lung. Rapid recovery followed the introduction into the pleural cavity of a drainage-tube, to which was attached a very thin rubber tube which permitted the exit of air but prevented the ingress of the same by collapsing.

BURIED WIRE SUTURES IN LAPAROTOMY AND HERNIA.—Schede (Hamburg) recommends the use of buried wire sutures to unite the recti muscles in closing abdominal sections. They remain in the tissues without causing irritation. He has also used them in the radical cure of hernia. The recommendation is based upon 270 cases, in which there were but 6 per cent. of recurrences as against 25 per cent. by previous methods.—*Münchener Medizinische Wochenschrift*.

INDICATIONS FOR OPERATION IN BOWEL OBSTRUCTION.—Schlange (*Norsk Magazin for Lægeridenskaben*) calls attention to the importance of individualizing every case of ileus, both from an operative and a prognostic point of view. Such cases may be divided into three classes:

1. The abdomen is more or less distended, the intestinal coils being visible externally and showing peristaltic movements, either spontaneously or after mechanical excitation, such as percussion, and intestinal sounds or gurgles being heard on auscultation. It may be assumed that no diffuse peritonitis is present, as it paralyzes the gut and prevents peristalsis. On the other hand it is probable that there is a local obstructive cause, and although it may be difficult to make out the exact nature of such a cause, abdominal section is indicated, especially when the symptoms appear suddenly and persist or intensify. As a result, internal or hernial strangulation will be found present. If the symptoms have developed slowly and are not severe, and particularly when the similar attacks have been previously gone through, a more expectant plan of treatment is advisable. Tumors or adhesions are usually the cause in such cases.

2. The abdomen is distended like a barrel, the intestinal coils neither visible nor palpable, and all signs of peristalsis are wanting by palpation and auscultation. Diffuse peritonitis may be diagnosed with a consequent general intestinal paralysis.

Operative interference, as a rule, hastens death, and offers but little chance of recovery. A few cases recover without surgical intervention, which at most must be of a minor character, as a fistula to relieve distension, etc.

3 A limited portion of the intestine is distended, while the rest of the abdomen is soft and flaccid, this coil of intestine showing no sign of peristalsis. The symptoms are acute, and the patient sinks rapidly. A large coil of intestine has become incarcerated by a kink or band; generally, peritonitis is absent, but early laparotomy is the only life-saving resort.

BOWEL OBSTRUCTION FROM GALL-STONES.—Koerte (*Muenchener Medizinische Wochenschrift*) has operated three cases in which the condition was due to gall-stone. The seat of obstruction was twice in the duodenum and once in the sigmoid flexure. The calculi were not large enough to render a mechanical stoppage possible. Reflex occlusion from the irritation of the stone is assumed as the cause.

RADICAL CURE OF INGUINAL HERNIA.—Thiriar (Brussels) has made use of decalcified bone plates to prevent relapses after operations for the radical cure of hernia. The recommendation is based upon twenty-one cases, in which a firm, resistant cicatrix resulted and relapses did not occur. The bone plate is absorbed and replaced by cicatricial tissue. After the sac is resected and its stump reduced, a decalcified bone plate is inserted between it and the abdominal wall on the inner aspect of the internal ring, where it is fastened by catgut sutures.—*Report of French Congress of Surgery.*

Schwarz accomplishes a similar result, on the principle made use of in femoral hernia with the pectineus muscle or fascia, as follows:

The sac is ligated, resected, and its stump reduced in the usual way. The sheath of the rectus is opened and a flap of the muscle, one and a half to two inches in breadth, dissected up. This retains its connection at one end with the muscle, of which it includes one-half of its thickness; it is pushed through the internal abdominal ring and fastened to the crural ring below, the oblique and transversalis muscles above, and to the external ring, filling the inguinal canal with a thick mass of muscular tissue. The canal and rings are then sutured, the sheath of the rectus closed, and the operation completed.—*Ibid.*, *Wiener Medizinische Presse.*

TRIGEMINAL NEURALGIA.—Schulze-Berge (*Münchener Medizinische Wochenschrift*) reports a case of tic douloureux in which complete recovery followed stretching, after resection of the terminal branches had failed. In the discussion of the paper, Esmarck and Gussenbauer recommended in such cases a thorough trial of a "course" of castor oil before operative procedures are resorted to. They claim that nine out of ten cases will be cured in this way.

TREATMENT OF SPINA BIFIDA.—Hildebrandt (*Münchener Medizinische Wochenschrift*) considers operative interference contra-indicated when paralysis is present. The sac should always be opened. In the Göttingen clinic, of thirteen operated, ten were cured, the last eight without a death.

INCISION AND DRAINAGE OF THE PERICARDIUM.—Siewers (Helsingfors) considers puncture of the pericardium but a palliative measure. Four out of nine of his cases recovered after incision and drainage. An opening is made in the fourth or fifth intercostal space and the pericardium tapped; following the trocar as a guide, an incision is then made with scissors, knife or forceps, which are opened. Care should be taken not to evacuate the fluid too rapidly, not to injure the internal mammary artery and not to open the pleural cavity. Two drains are inserted, and the cavity is not irrigated.—*Norsk Magazin for Lægevidenskaben.*

GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D. AND J. NICHOLAS MITCHELL, M.D.

CONCEALED HÆMORRHAGE.—In concealed hæmorrhage the prognosis is very grave for both mother and child. In external hæmorrhage the prognosis is more favorable, especially for the mother. This may be explained by the fact that the

uterus is less distended, thus causing less shock, and that the detachment of the placenta is often incomplete. The earlier diagnosis also lessens the mortality. About eighty-five per cent. of the children are still-born. In shaping the mode of treatment we must consider only the welfare of the mother, because the child will generally perish. The main object of our action will be to effect delivery as soon as possible. At the time when the patient is first seen the soft parts are, as a rule, unprepared, and only Cæsarean section or the accouchement force can effect delivery. In cases where we have the alternatives, stop the hæmorrhage or lose the patient, such radical procedures are justified. In some cases we use Barnes's rubber bags, or dilate the cervix through deep incisions. Where the hæmorrhage is mainly external, and the patient is in a fair condition, a more expectant plan of treatment may be employed. We then endeavor to stop the hæmorrhage, and leave the course of labor as much as possible to nature. Bandelocque advocated the use of the ice-bag over the suspected seat of the hæmorrhage, and a tight abdominal binder. Tamponing the vagina has been variously recommended. It may, by dilating the vagina, cause uterine contractions, but these can be only feeble in the overdistended uterus, and they are apt to increase the shock which so frequently accompanies cases of concealed hæmorrhage. In external hæmorrhage it produces a concealed hæmorrhage with its graver prognosis; it also prevents the observation of the progress of labor, and the increase or cessation of hæmorrhage. Rupture of the membranes, diminishes the contents of the uterus, and causes its contraction. If labor is well advanced it is a safe and excellent method, but early rupture of the membranes—that is, before they have produced dilatation of the cervix—delays the progress of labor, and, should version be necessary, the operation would have to be performed under very unfavorable circumstances. If the soft parts are dilated or dilatable, and rapid delivery is indicated, version, forceps, or craniotomy, may be undertaken—version preferably by the bipolar method if the head is movable above the brim; forceps in all cases where the head has entered the pelvic canal; when the child is dead, craniotomy may be performed, and the perforation of the living child or symphysectomy are justifiable procedures in cases of accidental hæmorrhage complicated by pelvic contraction. Ergot should not be administered until the birth of the child is soon to be expected. Post-partum hæmorrhage very frequently follows accidental hæmorrhage caused, no doubt, by uterine over-distension and a condition of general anæmia and muscular relaxation. Syncope and collapse are also observed. To meet these complications we must prepare ourselves before the birth of the child. The value of the intra-uterine tampon of iodoform gauze should be emphasized.—Julius Rosenberg, M.D., in *American Journal of Obstetrics*, 1893.

CURE OF MAMMARY ABSCESS.—S. L. Webber, M.D., describes a method of after-treatment for mammary abscess which has given brilliant results. The breast is opened by radial incisions, as many as may be required, sometimes six or seven if for a whole breast. The finger is introduced and pockets and tracts searched for. All the débris is scraped out of the cavities with a sharp spoon, while the irrigator plays. This should be most thoroughly done. The incisions and communications between them should now be packed with strips of sterilized gauze which has been soaked in 1 pr. ct. carbolic solution; more such wet gauze is piled on the breast, and the dressing is covered with a sheet of rubber protective; then the bandage—that is a moist dressing—is applied. The first change of dressing is made in thirty-six (36) hours. The strips of gauze are all pulled out of the wounds. The wounds look fairly clean and healthy. They are then washed out gently with any kind of a aseptic solution and dressed as before. These two moist dressings are essential to the success of the method. Twenty-four hours later the second change of dressing is made. Care and gentleness in handling the breast is the watchword from now on. The wounds are not packed this time. A thin layer of gauze is laid on to cover the whole breast. A large flat sponge, surgically clean, is now taken (large enough to cover the whole breast); it is soaked in a one per cent. solution of carbolic acid, then squeezed out as dry as it possibly can be. This laid on the breast, then a sheet of rubber protective, then a breast bandage as tight as force can make it. The idea of the dressing is to compress the breast against the chest-wall. A very important point is that the breast should be put in the dressing in such a manner that it remains elevated. The nipple should be in the centre of the breast and the centre of the compressed area should be over the nipple. The bandage should be as tight as the patient can bear it. To add to the compression after the bandage was put on, he frequently resorted to the following expedient: Everting

the upper edge of the dressing, a few ounces of one per cent. carbolic acid is poured upon the sponge; that causes the sponge to swell up a little and adds that much to the compression. Twenty-four hours later, the woman being in a recumbent position, the dressing is again changed. The breast is gently irrigated off, no attempt being made to irrigate through any wounds. The wound is now practically aseptic. If the breast has been properly elevated, and kept elevated by the dressing, even the edges of the skin will be in proper apposition. A wet-sponge-compression dressing, as at the last dressing, is again applied.

By this method of treating mammary abscess we endeavor to accomplish the following:

1. The operation must be radical as described. All pus tracts and cavities to be made freely accessible; then all pus, débris, necrotic and unhealthy tissue curetted and washed out, only healthy tissue to be left behind.

2. Then, by means of the moist dressing applied in the manner described, we subdue the inflammation, remove any congestion, and so bring any further pus formation to a standstill. Drainage is secured through the wet gauze packed into the amply large incisions. Granulative formation is begun. All this is accomplished in about three days.

3. By means of continuous, firm, uniform pressure, all further suppuration is prevented and the surface of the wounds are made to adhere together and unite such as in union by first intention.—*Amer. Jour. of Obstetrics*, 1893.

CARCINOMATA.—It is a well-known fact that carcinomata, irrespective of the form of the cells, show a very different degree of malignancy according to their place of origin. The flat cutaneous carcinoma on the nose gives a radical cure after removal in about 70 per cent. The carcinoma of the lower lip was removed, with freedom from relapse for over three years, in 106 out of 277 patients. The carcinomata in the adjoining mucous cavities show a high degree of malignancy. Thus, in the nasal cavity and in the superior maxilla relapse followed in 61 per cent.; in the mucosa of the cheek, even in 80 per cent. of the operations.—*Dr. H. P. Newman, Amer. Jour. of Obstetrics*, 1893.

THE ETIOLOGY OF PUERPERAL INFECTION—In a discussion upon this subject at a meeting of the New York Obstetrical Society, Dr. Jewett said that though his experience had been that fever cases multiplied as the wards became crowded, he was strongly disposed to believe that the infection is practically always by contact. Dr. Edgar at one time believed it proper to give a bichloride douche of 1:800 prior to labor, but a more extended experience has shown him that the patients do better without it. Now he uses it only for special reasons, such as gonorrhœal infections. In looking over the record of twenty-seven hundred cases of labor occurring in the tenement-house district, some of them in the vilest cellars and garrets imaginable, he had found that, apparently, these surroundings had no deleterious effect on the patients. Dr. Malcolm McLean did not much believe in the utility of vaginal douching as a routine practice. Personal contact is the great danger in all obstetrical cases. The vulva and surrounding tissues should receive a very thorough cleansing, and when once clean should be kept so. Dr. Grandin said that the puerperal fever was a wound infection, the result of contact and not of surroundings; its comparative rarity at the present time is due to our recognition of the importance of cleanliness. The death rate from sepsis in the New York Maternity Hospital used to vary from seven to twenty-five per cent.; at present, it is from one-fourth to one-eighth of one per cent. It is to-day an inexcusable disease except in those very rare cases where the patient carries within her the source of infection, viz., pus in one or other of the Fallopian tubes, which suddenly becomes virulent. Dr. Grandin brought up another point in connection with the management of the puerperism. Is it advisable to allow the patient, after thirty-six or forty-eight hours, to get out of bed to the commode? He lacked the courage to do so, though he allowed them to assume the semi-recumbent posture on the bed-pan, as this facilitates drainage of the vagina; he feared to allow more liberty because of the possible danger of embolus or puerperal venous thrombosis. For ten years the president has allowed his patients to rise within a few hours after delivery to pass water, and in no instance yet had he any cause to regret it. Dr. Edgar, by referring to the statistics of over two thousand cases of confinement among tenement-house women, had found the majority sat upon the vessel as soon as they felt a desire to empty the bladder after labor, yet out of this large number of cases there had not been a

single instance of sudden death nor one of secondary post-partum hæmorrhage. Dr. Jewett allows the patient to assume a sitting or half-sitting posture for the purpose of emptying the bladder, and also, after a few days, to take meals. In closing the discussion, Dr. J. M. Thomas said that while not believing in the theory of no heteroinfection except by direct contact,—inoculation,—he thought that while our aseptic practice was not perfect, we could not afford to ignore our surroundings or escape from the fact of their indirect bearing upon our results in actual practice. Dr. Grandin's position in regard to the early use of the commode during the puerperium, while commendably cautious in spirit seemed to Dr. Thomas practically unwarrantably so if the cases were well chosen. It has been his practice, for the past four or five years, to resort to the commode at once in normal cases whenever the patient experiences any difficulty with the use of the bed-pan. Others have had even more experience and no ill result has ever occurred. It is surely a great comfort to the patient, and aids in the expulsion of vaginal clots.—*New York Journal of Gynecology*.

ANÆSTHETICS IN GYNÆCOLOGY.—The after-effects of chloroform and of ether are determined by the quantity of the anæsthetic given, and as we now know how to give ether in such a way as not to require proportionately more weight for weight, than of chloroform, there is no reason to expect more after-sickness from the one than from the other anæsthetic. The immediate effect of chloroform is to stimulate to a slight extent the circulation, but this is rapidly followed by a reaction, which leaves the heart beating more slowly and less vigorously than normally. This depression increases if the inhalation be a very prolonged one, and may lead to very marked circulatory enfeeblement; but as soon as the operation is completed and the patient is put back into bed, the depression wears off and a very considerable acceleration of the pulse occurs, together with an increased force of the heart's action. The effect of ether is one of continuous stimulation alike of respiration and of circulation, which, however, wears off as the patient comes completely under the ether, and little or no after-reaction follows after the completion of the operation other than what is attributable to the usual procession of events of recovery from surgical shock. Although immediate hæmorrhage under chloroform is less than under ether, yet as soon as the patient passes from under the eye of the surgeon the hæmorrhage or oozing commences. Thus, bleeding under ether is seen at the time of the operation, and dealt with, that under chloroform may be masked by the enfeeblement of the circulation, and so escape observation until the condition of the patient calls attention to the bleeding. The writer says that in a large experience with chloroform he has had no death under the anæsthetic, but there were grave cases of peril, arising, apparently, from the depressing effect of chloroform upon the heart. The committee of the Royal Medico-Chirurgical Society instituted a comparison between chloroform, ether and the A. C. E. mixture, and advised that the last named be employed, because chloroform anæsthesia, though rapid, was dangerous, and ether anæsthesia not dangerous but slow. When we desire a rapid anæsthesia without struggling for such patients as those with feeble hearts, rigid arteries, etc., we should select ether rather than chloroform, which may involve unconscious struggling prejudicial to the patient's general local condition. Chloroform kills at the time of the operation if it kills at all, whereas ether kills as an after-result, from pulmonary complication or from renal troubles. Again, nausea and vomiting are alleged to follow ether more than chloroform. A further charge against ether is its assumed tendency to cause rupture of brittle arteries, and so determine cerebral apoplexy. These charges are by no means proven. In some cases tumultuous breathing does come on and inconvenience the operator. Catarrhal affections of the kidneys and bronchi are reputed as common sequelæ of ether administration, but the writer is convinced that such cases are rare. The initial struggling, the straining and misery of ether as sometimes given, are great evils; but when we discard this method and employ nitrous oxide in an initial anæsthesia, following up its use with ether, we do away with all these troubles. The plan commonly taught and adopted by some anæsthetists is that when an abdominal section has to be performed, anæsthesia is practically only required during the skin incisions. A very grave degree of shock always attends manipulations of the peritoneum and viscera, and, in view of this, profound anæsthesia should be maintained throughout the entire operation. From the recently published statistics of Dr. Julliard, of Geneva, it appears that the deaths under chloroform are about five times as frequent as deaths under ether.—D. W. Buxton, M.D., *British Gynecological Journal*.

THE FAILURE OF ANTISEPSIS IN TREATING PUERPERAL FEVER.—Schrader discussed the reasons why antiseptics has failed to meet its expectations in treating puerperal fever. He has observed some of the most severe forms of general infection immediately followed uterine irrigations when the original disease was limited to the endometrium. The connection between irrigations of the uterus and general septic infection was so evident that he was no longer a believer in the harmless character of uterine irrigations. He believes that any irrigation of the uterus in puerperal endometritis, even when the process is localized in the uterus, may cause general infection of the organism. The extension of infection is through the veins or lymphatics. The irrigation may wash septic material into a vein and thus cause an infection as shown by a chill, which the organism cannot conquer, or there may be a venous transfusion of irrigating fluid, without producing immediate symptoms, which may be of a serious character. The infectious material can enter the lymphatics by increased intra-uterine pressure.

The writer also believes that sudden contraction of the uterus caused by irrigating increases resorption, contrary to the prevailing opinion which he thinks is not in accord with the teaching of physiology on the formation and flow of the lymph. The presence of infectious material being granted, the advantage of a diminution of the resorbing surface is more than compensated by the greater amount of absorption. It is known that the current of lymph is also motionless in a resting muscle and that it flows fast in an active muscle. This law is equally good for the hollow muscle, the uterus. When this contracts, the lymph flows centripitally toward the heart, i.e., toward the uterine periphery and the broad ligaments. In the relaxations between contractions, the emptied lymph channels refill and with the next uterine contraction are emptied as before. In this manner the lochia with its bacteria or toxins are resorbed, or possibly the toxins may be taken up by endosmosis.

The more energetic the pains and the greater the relaxation of the uterus between them, the more rapid will be the current of lymph and the greater the resorption of the lochia. Resorption is not due to either contraction or to relaxation alone but to the constant change. On the other hand, resorption ceases, or nearly so, when the uterus is in a relaxed or paralyzed condition.

Exacerbations in perimetritis and parametritis are due to rupture of the encapsuled exudate by strong contractions. The line of demarcation can be broken through by other trauma, such as coughing, sitting up, standing up, etc. Exudations fixing the uterus act as nature's splints to secure rest of the diseased parts.

Vaginal irrigation is less dangerous than uterine, but ought not to be practiced. It produces uterine contraction to a less degree and washes away the lactic acid fermentation in the vagina which, as Döderlein has shown, will make harmless the streptococci.

The writer discountenances the cauterization of puerperal ulcers, all use of antiseptics in puerperal fever, even when it would appear a sin to omit them, such as intra-uterine interference in fever during labor, after putrescence of the secundines, after manual removal of stinking pieces of placenta one or two weeks after delivery. Immediately after labor there is no resorption from the uterine cavity. The investigations of Ashford with irrigations of salicylic acid have proven that resorption first plays a part on the third or fourth day. In the discussion of the above paper, Lomer agreed in general with the reader. He had had extensive experience with a large amount of material in Berlin and had never seen good results from permanent irrigation of the uterus and had observed much that was bad. He was in favor of discontinuing even a single washing out of the uterus. He warned those present not to use ergot which produced contractions.

Olshausen mentioned the publication of Glöckner of one hundred cases with and one hundred without prophylactic treatment, the latter showing the best results.—*Centralblatt für Gynäkologie*, No. 16, 1893.

SCHULTZE'S METHOD OF RESUSCITATION.—Two cases were reported where this method of swinging the child was employed in vain for deeply asphyxiated infants, and the autopsy showed hæmorrhage into the peritoneal cavity, presumably from the liver. Schultze in reply to this criticism cites authors to show that in deeply asphyxiated children the liver becomes intensely hyperæmic and capillary hæmorrhages or even extensive extravasations occur under the peritoneal covering of the liver. Sometimes the peritonæum ruptures and there is hæmorrhage into the abdominal cavity. It is due to prevention of respiration and circulation through the lungs.—*Centralblatt für Gynäkologie*, No. 15, 1893.

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

PILOCARPIN IN LARYNGEAL DIPHTHERIA.—Degle (*Wiener Medicinische Presse*, 1892, No. 44) has employed pilocarpin internally in four apparently bad cases of laryngeal diphtheria. It promptly lessened the dyspnoea and effected a cure. The saliva and perspiration were increased, but no bad effects were observed. Good results followed within twelve or twenty-four hours. He administered three to four centigrammes of the hydrochlorate with infusion of ipecac and syrup of senega in the twenty-four hours.

IMMATURE CATARACT AND THE BEST MEANS OF HASTENING MATURITY.—Dr. White commends the emptying of the anterior chamber by means of a paracentesis needle, and then rubbing the lens through the cornea in various directions, by means of a spoon, until pain is experienced; cold is then applied and rest advised. Usually, in a short time the lens becomes opaque.—*Archives of Ophthalmology*, xxi., 4.

USE OF ALKALOID MIXTURES IN OCULAR THERAPEUTICS.—The author says that the effect of a mixture of several alkaloids is greater than that produced by each substance separately, with less risk of toxic action. The best results were obtained by him from a collyrium composed as follows: Sulphate of atropine, 1 per cent.; sulphate of duboisine, 1 per cent.; hydrochlorate of cocaine, 2 per cent. This mixture produces a degree of dilatation of the pupils which is obtainable with no other mydriatic. A mixture of 0.3 per cent. of sulphate of atropine, 0.3 per cent. of duboisine, and 2 per cent. of hydrochlorate of cocaine is at least as powerful a mydriatic as a 1 per cent. solution of atropine and is less dangerous.

A solution containing sulphate of eserine, 1 per cent.; hydrochlorate of pilocarpine, 2 per cent., is an excellent myotic, and is well borne by the patients. A mixture of 2 per cent. solutions of hydrochlorate of cocaine and of pilocarpine possesses all the properties of cocaine, with this advantage, that it does not give rise to dilatation of the pupil and to disturbances of accommodation, like a pure solution of that alkaloid.—Dr. E. Berger, *Medical Week*, No. 9, 1893.

PURULENT OTITIS MEDIA ACUTA PRODUCED BY A PINCH OF SNUFF.—Dr. Haug reports the case of a young man accustomed to take snuff, who, being seized with sneezing, closed his mouth and lowered his head. Otitis media purulenta acuta developed, and in the pus discharged from the ear, after paracentesis of the drum, grains of tobacco were found, which had been forced there during the sneezing.—

Coryza, treatment (snuff):

Bismuth subnitrate,	
Benzoin, powdered,	āā grammes 6 (1-1½ drachms),
Boric acid, powdered,	grammes 4 (1 drachm).
Menthol,	centigrams 20
M. Sig.—A pinch occasionally.	— <i>Archiv. für Ohrenheit</i> , xxxii., 2.

A SNUFF FOR HOARSENESS AND NASAL ASTHMA.—The *Prager Medicinische Wochenschrift* gives the following formula: Cocaine hydrochlorate, one part; triturated camphor, two parts; bismuth subnitrate, sixteen parts.

THE EYE OF THE NEGRO.—In the last number of the Transactions of the American Ophthalmological Society, containing the report of the twenty-eighth meeting held at New London, Conn., in 1892, Dr. Chas. W. Kollock gives an interesting account of the peculiarities he had observed in the eye of the negro. It is well known, he observes, that the negro race in America is fast losing its identity as far as purity of blood is concerned, the mulatto being seen on every hand. Moreover, as one of the results of the great war, syphilis was introduced and spread extensively among them. Instead of the care that was formerly bestowed upon him by his owner, evil habits and careless living have taken possession of him, and today a race that thirty years ago was strong and healthy is now honeycombed with syphilis and its sequelæ. Before the war these people had little or no eye trouble beyond cataract; ulceration of the cornea, which now numbers its victims by the thousand, was almost unknown. Blindness or greatly impaired vision is found on all sides from this cause and the outlook is truly discouraging. Trachoma is com-

paratively rare; iritis is of very common occurrence, and in point of frequency stands next to ulcerative keratitis. Dr. Kollock has only seen three cases of myopia and only one of these was as high as -7 D. High grades of hyperopia seem to be equally rare.—*The London Lancet*, No. 3638.

SCOPOLAMINE HYDROCHLORATE, A NEW MYDRIATIC.—Kobert's experiments have shown that this substance is opposed, in general physiological action, to atropine; it does not stimulate the cerebral cortex (like atropine) but paralyzes it; and does not accelerate the pulse, but retards it.

According to Dr. Rahlmann, scopolamine excels, as a mydriatic and antiphlogistic, all other tropines in use. It is similar to hyoscine, in strength of mydriatic action, without sharing its disadvantages. Unlike atropine, it has no untoward after-effects. It does not disturb the appetite, nor does it cause dryness of the throat, in normal doses, or nervous restlessness, reddening of face, or frequent pulse, as in the case of atropine.

The anodyne and antiphlogistic effect of scopolamine is not second to that of atropine; a steady diminution of the hypopyon was observed in five cases after its application. It does not affect intra-ocular pressure, and will, therefore, in contrast to atropine, be readily borne where there is a pathological increase of the same. Scopolamine hydrochlorate is used in $\frac{1}{10}$ – $\frac{1}{5}$ per cent. solutions, which correspond to $\frac{1}{4}$ –1 per cent. atropine solutions. It acts best in divided doses.—*Munchener Med. Wochenschrift*, No. 8, 1893.

CAUSTIC PYROZONE.—In my opinion, this new compound of hydrogen dioxide 25 per cent (ethereal), promises to take an important place in nasal and throat surgery. With none of the very depressing and oftentimes ill effects of chromic acid, and the lesser evils of tri-chloroacetic, caustic pyrozone seems to offer quite an efficient substitute, doing a maximum of work with a minimum of discomfort. As an application to polypoid tissue, and for the reduction of hypertrophies it is invaluable.—Holbrook Curtis in the *New York Therapeutic Review*, April, 1893.

OZÆNA: NITRATE OF SILVER AND CHLORIDE OF ZINC IN ITS TREATMENT.—Moure (*French Congress for the Advancement of Science*, 1892). For the past year this author, who has written previously on this intractable disease, has used a spray composed of a concentrated solution of nitrate of silver at 10, 15, 20, 25 per cent, daily, or on alternate days, as required. As a result, several patients have been much improved in one month, and others needed an occasional application after an interval of several months. The results have been better, and the treatment has been most efficacious and durable when the affection is limited to the nasal fossæ and does not extend into the ethmoidal or other sinuses, and when the secretion is abundant. A few patients suffered from inflammatory reactions accompanied by frequent hæmorrhages, which prevented the regular continuation of the treatment, but generally the results were satisfactory.

EAR-ACHE.—G. C. Savage, M.D., editor of the *Ophthalmic Record*, decries, in the March issue of his journal, the use of morphine, cocaine, detergent sprays, and post-pharyngeal painting with astringents, for the relief and cure of ear-ache. He thinks that we have at our command a remedy that is far more convenient and much more effective than a continuous stream of hot water, however skilfully directed. This remedy is chloroform, dr. j. to dr. jss., in olive oil, q.s., ad. oz. j. The ear should first be cleansed by means of absorbent cotton on a tooth-pick or probe, in a most gentle manner, after which the ear should be filled with the solution, the patient lying for ten minutes on the well side. This can be repeated as often as necessary. Usually, it does not have to be repeated often. Its power to relieve pain, reduce inflammation, and prevent suppuration, is wonderful. For obvious reason the mixture should not be heated before being dropped into the ear.

NASAL INSUFFLATION OF SOZOIDOL-SODIUM IN WHOOPING-COUGH.—Dr. Paul Guttman (*Therapeutische Monatshefte*, Jan., 1893, *Fortschritte der Medizin*, April, 1893) reports favorable results from this treatment, but not such brilliant ones as those of Dr. Schwarz, of Constantinople. In no instance has he succeeded in cutting the course of the disease short in four or five days by means of daily insufflations. In a number of cases, however, their favorable action has been undeniable. In six cases, treated in the Monbte Hospital, diminution of the frequency and severity of the paroxysms was noted; in four of them, in from three to six days, in two in eight days. In twenty-four cases, treated at the Poliklinik, also a favorable influence upon the course of the disease was observed.

MONTHLY RETROSPECT OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D., AND FRANK H. PRITCHARD, M.D.

CAUSTICUM IN HEMIPLEGIA.—Right side particularly affected, often accompanied with loss of memory and of will power together with vertigo, or rather a sense of dizziness in the act of rising up or of lying down, slowness of speech and stammering; constipation and urinary troubles; paralysis of the facial muscles; occurring in pale and debilitated subjects caused by exposure to cold wind; dysphagia also, apart from any morbid growth in the gullet, but rather due to some amount of paralysis of the muscles.—Dr. A. C. Clifton, in the *Monthly Homœopathic Review*, June, 1893.

URINARY SYMPTOMS OF CAUSTICUM.—Paretic conditions of the bladder, especially in old men, involuntary and frequent micturitions, followed by dribbling of urine, worse when lying down and during the night. In cases of enlarged prostate, the irritability of the bladder is relieved and patient enabled to retain his urine for a longer time. Nocturnal enuresis occurring in the early hours of the night in poorly-fed nervous children.—*Ibid.*

CHELIDONIUM MAJUS IN PNEUMONIA.—Affects especially the right lung, accompanied by very quick and short inspirations, pain on deep inspirations, and flapping of *alæ nasi* (lyc.). Dry heat of the skin, quick pulse. Short, dry hacking cough causing pain, expectoration tenacious and difficult.—*Ibid.*

CINNAMON IN UTERINE HÆMORRHAGE.—Useful in 1x dilution for arterial hæmorrhage from the uterus, in threatening abortion of pregnant women, and in excessive menstruation with much debility, faintness, yawning, or gaping arising from loss of blood, and where *china* is to some extent indicated.—*Ibid.*

A TYPICAL CASE OF SCIATICA INDICATING COLOCYNTH.—Mrs. A., æt. about forty, was taken with very severe pain in stomach and left ovarian region. The pain was so intense at times that she would become delirious and vomit with great difficulty. Treatment met with but partial success, when suddenly the pain appeared in the left sciatic nerve and continued periodically in that region for one year. When first seen she had intense drawing aching pains, ending in twitching in the calf of the leg. Cramping pains would run from the hip to the foot and *vice versa*. Occasionally there would be a throbbing which would invariably end in a drawing pain along the whole limb. Colocynth 3x was prescribed to be taken every one or two hours in water. She was discharged cured, in four days.—*Medical Era*, January, 1893.

CALC. FLUOR. IN HÆMOPTYSIS.—Dr. M. J. Bliem reports the following: Mr. H. was sent from Illinois to El Paso, Texas, suffering from hæmorrhagic pulmonary tuberculosis and was temporarily relieved. The hæmorrhages returned but were partially controlled by geranium and china. He was then removed to the lower altitude of San Antonio but the bleeding continued in spite of remedies. Calc. fluor., trit. 6x, a 4 gr. powder four times daily was prescribed, and the bleeding at once lessened steadily, till in a week all traces of blood in the sputa had disappeared. Both lungs were extensively diseased yet the bleeding did not recur during the remaining month of his life.—*Southern Journal of Homœopathy*, April, 1893.

PHOSPHORUS IN PURPURA HÆMORRHAGICA.—Dr. A. Spiers Alexander reports the following case with remarks on the pathogenetic action of phosphorus: Laura

C., æt. 17, was a servant in a second-rate hotel where she had very hard work, late hours and indifferent food. For some time she had been feeling increasingly weak and poorly, with shortness of breath, palpitation, and no catamenia for several months. The day before her admission to the hospital, dark spots appeared all over her body quickly followed by an attack of hæmatemesis. She was somewhat anæmic, the lips and mucous membranes being somewhat pale. The face, shoulders, arms, trunk and lower extremities, were covered with petechiæ of deep purple color, varying in size from a sixteenth to a quarter of an inch, being largest and most numerous on the hips and thighs. The urine was found loaded with blood. Patient was put to bed, diet limited to milk and soda water, while *phos. 6* was given every two hours. Improvement was noted the following day, the hæmatemesis ceasing after the first few doses. The medicine was given at longer intervals, and by the fourth day the urine was entirely free from blood and albumin. On the seventh day the menstrual period returned after being absent for six months. The petechiæ were all fading, and by the nineteenth day the patient was dismissed, no trace of them remained.

In phosphorus poisoning, not only does extravasation of blood occur, but the blood itself is changed. It is found to be dark, fluid, and non-coagulable, the red corpuscles few in number and somewhat disintegrated. Experts are not yet agreed as to whether the hæmorrhages are due to these changes or from alterations in the bloodvessels. Virchow has determined that the well-known fatty changes which take place in the heart, liver, muscles, etc., extend to the bloodvessels, even as far as the minute microscopical vessels. It therefore seems possible that the extravasations are due to loss of integrity of the vessels rather than changes in the blood itself.

Although the pathology of purpura hæmorrhagica has not been positively determined, it seems probable that there is a pathological correspondence between the disease and its drug simulacrum.

Analogy might justly lead to the conclusion that if phosphorus poisoning produces fatty degeneration of the capillary vessels, and that the hæmorrhagic effusions are secondary, there may also be a similar condition as the basis of the hæmorrhages of purpura.—*Monthly Homœopathic Review*, May, 1893.

ANGINA PECTORIS DUE TO GOUTY DYSCRASIA.—Proctor cites a case occurring in a butcher, an active man of about 65 years. The attacks had not increased much in frequency and intensity up to the time he came under his care. He was placed upon such treatment as seemed homœopathically indicated, but without any curative result. After about six weeks there seemed to be indications that a gouty dyscrasia lay at the bottom of the whole trouble. A strict antiarthritic dietary was enjoined, and the medicinal treatment more generalized, *colch.*, *merc. sol* and *potass. iod.* being chiefly employed. After about ten days the patient complained of gouty inflammation localized in one of the great-toes. All medicine was stopped for fear of causing metastasis to another part. When the gouty joint was fully developed the anginal paroxysms absolutely ceased, and from that time there has not been the slightest recurrence.—*Ibid.*

ACHILLODYNIA AND GONORRHOEA.—Prof. Albert, of Vienna, reports under this term an affection characterized by pain at the point of insertion of the tendo Achilles to the os calcis. The pain is violent, and especially noticed on walking and standing, but disappearing completely on lying down or sitting. Objectively, a slight swelling is found, appearing as though the insertion of the tendon were thickened. It is as hard as the tendon itself and not sensitive to pressure. Sometimes it seems as if a bilateral enlargement were to be felt at each side of the insertion. The pain is obstinate and yields to no allopathic treatment. Dr. Welsch, of Augsburg, has treated three such cases; and traces them to gonorrhœa. He prescribes, both internally and externally, *Thuja occid.* in the tincture. A solution of 1:9 is applied on compresses and 4 to 6 drops of the tincture given three times a day internally. In cases of pain in the knee or hip he employed the same treatment. *Thuja* acts specifically, like *copaiva*, upon the mucous membrane of the urethra, bladder and ureters, and even kidneys, but it also has a deeper influence in that it removes the articular and tendinous localizations of gonorrhœa.—*Archiv. Fœr Homœopathia*, No. 5, 1893.

TREATMENT OF LYMPHANGITIS.—Dr. P. Jousset divides it into superficial and deep lymphangitis. Superficial lymphangitis is sometimes preceded by a slight

chill and a febrile movement accompanied by malaise. The local symptoms may be 24 hours in developing and thus render diagnosis difficult. They consist of reddish, wavy streaks running parallel with the limb and anastomosing with each other along the course of the limb. The color is a light rose, the pain intense and burning and aggravated by touch. Edema is only present when a larger lymphatic is affected which may be felt like a hard and tense cord, under the finger. The glands are also enlarged and tender. The course of the disease is continuous and more or less rapid, according to the acuity of the symptoms. In a benign case the symptoms may last only three days or so but in general it persists for 15 days.

Deep lymphangitis is very rare and incompletely described. It is sub-aponeurotic and characterized by two principal symptoms: a pungent and lancinating pain disseminated in multiple foci and occupying a fixed seat. The scattered foci have no tendency to unite. The deep glands are only affected when the disease tends to affect the superficial lymphatics. Suppuration is said to be the termination of this form. Belladonna and mercurius are the two principal remedies.

Belladonna.—The action of belladonna upon the skin is well known. This drug if administered to a healthy human being produces redness similar to scarlatina and erysipelas but no proving can be found where it produced tense cords as in lymphangitis. Yet it induces swelling, pain and redness of the glands and is of clinical value.

Mercurius.—Mercury no more than belladonna produces directly the symptoms of lymphangitis, but its action upon the skin and lymphatic glands is extremely well marked. But clinical use has proven the worth of both these drugs in this disease. The writer is in the habit of alternating these two drugs according to the intensity of the disease. The patient takes from 4 to 8 doses during the 24 hours, giving the mother tincture of belladonna and mercury in the form of calomel, in first trituration. In case of great œdema one may substitute apium virus, 3x for these. As in erysipelas the patient should keep his room during the entire course of the disease.—*L'Art Medical*, No. 5, 1893.

RHUS TOXICODENDRON IN CHRONIC DIARRHŒA.—Dr. A. Villers was consulted by a priest of 64 years, who leading a regular life, had suffered for two years from chronic diarrhœa. It would appear after every exertion, after eating bread, or cake and without any cause in the early morning hours, between 2 and 4. The stool would appear very violently, with rolling in the abdomen, and a feeling of pressure in the right inguinal region towards the groin. It was retained with difficulty, especially in the morning on awakening, was passed with a good deal of noise, was very thin, odorless and mixed with a few firm shreds. He had a few hæmorrhoids, had not been dyspeptic before this appeared, and had not taken purgatives. No cause known. *Rhus. tox.*, 30x, a drop twice a day, changed the stool in three days, so that it was entirely normal and remained so for 14 days, till, after indulging in white wine it returned, but the hæmorrhoids did not reappear. Five days' use of the same remedy removed this and for the last year he has been well.—*Archiv. fuer Homœopathie*, No. 5, 1893.

TREATMENT OF INSOMNIA.—Dr. Harvey Dale, after reporting a series of cases of insomnia cured, makes the following remarks concerning the homœopathic therapeutics of this distressing symptom: Prominent among the homœopathic remedies are *belladonna*, *chamomilla*, *cimicifuga*, *coca*, *coffea*, *hyoscyamus*, and *stramonium*.

The *belladonna* patient is on the verge of delirium; wants to sleep but cannot. A glimmer of homœopathic light on this drug shines through the august pages of so infallible and allopathic an authority as the *National Dispensatory*. The eminent Dr. Stillé says: "The insomnia, hallucinations, blindness, etc., which large doses induce, may be attributed to the hyperæmia which they cause on the brain." And again: "The alleged hypnotic power of medicinal doses of belladonna may be referred to the diminution of blood which it occasions in the cerebral vessels." Evidently, the word "alleged" is thrown in as a sort of apology for the explanation which, from his point of view, does not explain. *Chamomilla* is at once suggested by its familiar, irritable restlessness, accompanied by a sleepy feeling but no sound sleep. *Cimicifuga* is characterized by melancholia, fears of going crazy, and withal absolute and obstinate insomnia. *Coca* is reputed to produce a mild cerebral excitement, differing from that of *coffea* in intensity mainly. *Hyoscyamus* and *stramonium* are to be thought of under conditions of febrile excitement with marked delirium. Stillé records of *hyoscyamus* that it produces in full doses "a loquacious sub-de-

lirium," and again that in small doses it "produces sleep, sometimes of considerable duration, in excited conditions of the brain, as in mania, delirium tremens, meningitis, and where ordinary hypnotics are inadmissible." *Coffea* is indicated by great mental activity, uninterrupted flow of ideas, acuteness of all the senses; in a word, "sleeplessness from excessive and physical activity."

The symptomatology of each of these remedies readily suggests its sphere of usefulness. *Chamomilla* has been called the child's remedy, a distinction which holds good here. *Cimicifuga* is often valuable, especially if antecedent or coexistent rheumatism can be discovered. *Belladonna* seems to be of special utility in convalescence from acute diseases. *Coffea* offers the most exact picture of insomnia as it usually presents itself to the practitioner, and after having given it numerous clinical tests, the writer feels disposed to give it first place among homœopathic sleep-producing agents.—*Transactions of the Homœopathic Medical Society of Wisconsin*, 1892.

COLOCYNTH.—John W. Ellis, M.D., L.R.C.P., F.E.S., has prepared a study of colocynth after the plan first put into practical operation by the Medical Investigation Club of Baltimore. The study is quite an elaborate one, and closes with the following suggestions relating to the therapeutic applications of the drug. From the pathogenesis of the drug, as well as from practice, we find that the chief indications for colocynth in muco-enteritis are: pain of a spasmodic (cutting or griping) character, affecting chiefly the umbilical and hypogastric regions, generally relieved by stooping forwards and by pressure, and usually accompanied by diarrhœa and flatulent distension. The pains are also temporarily relieved by discharge of stool or flatus, and are usually increased by food, although we note that two of the provers found the pains greatly relieved by taking coffee.

The diarrhœa for which colocynth is applicable may be merely a loose pappy stool, usually preceded by some colic or pressure in the hypogastric region, and often attended with much rumbling of flatus, or it may be watery or bilious, or even bloody, and although in two provers the pappy stools were accompanied by a feeling of weakness of the sphincter, which rendered retention of the stool even for a short period so difficult that there was scarcely time for the necessary change of base (aloes), the characteristic rectal condition attending the severe forms of colocynth diarrhœa, is one of violent tenesmus (*mercurius cor.*).

The use of colocynth in diarrhœa from emotional causes is not deduced from the provings.

The hard stools produced in some of the provers are evidently due to a secondary action of the drug.

Colocynth is distinctly homœopathic to sciatica and neuralgia affecting the anterior crural nerve, as is evidenced by the richness of our provings in these symptoms. It is probably in sciatica and neuralgia dependent upon rectal irritation, and in that of a rheumatic character that colocynth will be found most useful; where the pain is shooting or tearing, usually worse at night, and where it may be accompanied by numbness or cramp of the muscles of the leg.

The headaches produced by colocynth are mostly frontal and temporal in situation, and most frequently pressive in character; there is some tendency for the left side to be more affected than the right, though the disproportion is not great. In most cases the headache is increased by stooping and by movement, and is frequently attended by neuralgic pains in the eyeballs, orbits, and face. In those provers in whom pain attacked the vertex, the scalp became tender, a symptom again foreshadowing a rheumatic condition. Whether colocynth will prove of service in pure migraine, or whether good results will only follow its use in sympathetic headaches, facial neuralgia, and toothache from gastro-enteric disturbance, must be decided by experience.

Colocynth has been referred to as a palliative of the pain of acute glaucoma and iritis, and Hughes says "it has been found of service in the violent pains in the eyeball which precede the development of glaucoma."

Dr. Trites regarded colocynth as a sovereign remedy in orchitis (one prover had drawing pains in the left testicle). Colocynth has been found useful in ovarian neuralgia; while in that form of ovaritis accompanied by general abdominal tenderness Ludlam considers it, after belladonna, more useful than any other medicine. In the case of one of Frohlich's female provers there were produced "stitches in both flanks, apparently connected with the ovaries," but without any other symptoms of disturbance of these organs. Cases of the dissipation of ovarian tumors by the adminis-

tration of colocynth have been recorded, but the records are so vague that little reliance can be placed upon them.

From the similarity of its arthritic symptoms to those dependent upon the gouty diathesis colocynth deserves a trial in these conditions; while the dry, scraped throat, the laryngeal irritability, the oppressed breathing, the stiff neck, the intercostal neuralgia, and the sacral aching with hæmorrhoids, so closely resemble similar conditions in gouty or lithæmic subjects as to warrant the expectation that colocynth will be found useful in the treatment of such individuals.—*The Journal of the British Homœopathic Society*, April, 1893.

A STUDY OF RANUNCULUS BULBOSUS.—This remedy has an elective affinity for (1) the muscles and the nerves supplying the muscles of the whole body, and (2) for the skin.

1. Its muscular or musculo nerve action. This is of the rheumatoid or neuralgic-rheumatic type. The muscles of the nape of the neck, of the back, of the chest walls, of the abdomen, of the arms, thighs, and legs. The pains felt in these muscles are described as pressing, aching, dull, sharp, stitching, or as if from "subcutaneous ulceration," catch the breath; are worse on movement, and in walking, and in the morning and evening. They exactly correspond to the pains known as pleurodynia, muscular rheumatism, neuralgic rheumatism, lumbago, etc. The pains referable to the diaphragm and the muscular coats of the stomach and intestines cause a sensation like colic, with soreness, tenderness or pressure, and great uneasiness. There are pains also in the tarsal joints and in the heels of a neuralgic-rheumatic type, aggravated on walking.

2. Its action on the skin, including the mucous membranes. On the skin proper the irritant action is primarily local; that is, it is produced by the actual contact of the plant, but it is not confined to this, as the irritation spreads to parts which have not been touched, and long after the original irritation has seemed to subside it breaks out again in a peculiar and unique manner. It shows all grades of inflammatory action from redness, with itching, to blisters, ulcers, or even sloughing. Vesicular and pustular eruptions occur, often in patches, with pain and intolerable itching. The scalp is itchy. Such eruptions and inflammatory states indicate, as will be afterwards pointed out, the use of the drug in vesicular erysipelas, herpes zoster, various vesicular and pustular eruptions, and nettle-rash. Minor actions, such as headaches, are noted in the proving.—Dr. Dyce Brown, in the *London Homœopathic Hospital Reports*, vol. ii.

HEAD SYMPTOMS OF RANUNCULUS.—Ranunculus causes a considerable amount of headache, the most typical and marked being over the right eye, aggravated by lying down and relieved by walking about and accompanied by vertigo and a full feeling, as if the head were distended. The pains also occur in the forehead and eyeballs, abating after rising in the morning. The hairy scalp is also affected by a crawling sensation, and burning, pricking, with sense of fulness of blood. This form of headache is common in rheumatic states.—*Ibid.*

EYE SYMPTOMS OF RANUNCULUS.—The eyes display very distinct irritation of the conjunctiva, smarting as if from smoke or from the presence of a hair, with injection of the conjunctiva, and burning soreness of the lower lid. Pain in the eyeball of a pressive character is also experienced. These symptoms seem to be of rheumatic type.—*Ibid.*

GASTRIC SYMPTOMS OF RANUNCULUS.—Here the only characteristic symptom is a burning sensation in the region of the cardiac orifice, occurring in four persons who had eaten chicken broth in which the root of the ranunculus had been cooked, and a sense of pressure in the pit of the stomach with soreness when touched. The latter is probably myalgic, and would suggest ranunculus as a remedy in myalgia of the stomach, similar to bryonia, actea, and arnica, and in harmony with its myalgic action elsewhere. Nausea is several times complained of, with sense of want of breath.—*Ibid.*

ABDOMINAL SYMPTOMS OF RANUNCULUS.—The pains in this region are characteristically muscular. Those described as colicky are evidently not from mucous membrane irritation, but are in the muscular coat of the bowels. This harmonizes with the whole genius of ranunculus. All its abdominal pains are clearly myalgic and point out ranunculus as a chief remedy in muscular pains in the abdominal

walls and diaphragm. These pains have generally a marked neurotic element in them, and such are the pains of ranunculus everywhere. The description of the "colicky" pains also shows clearly to my mind, that they are not true colic, but myalgic.—*Ibid.*

ACTION OF RANUNCULUS ON THE CHEST.—Here we have the same interesting myalgic pains as we have seen in the abdomen. In fact the amount of pain in the muscular part of the chest wall is unique. These pains are felt in all parts of the chest walls, in front, at sides, and round the back. They are of dull, aching or pressive, or sharp, sticking character, lasting for a long time, causing difficulty in breathing, the pain catching the breath. These are aggravated by movement of the body, by taking a deep breath, by walking; frequently they are stated to prevent lying on one side as in the abdomen as from "subcutaneous ulceration." The painful spots are frequently tender to the touch, and even the contact of the clothes is painful. They occasionally move from one part to another, and alternate with the abdominal pains or pains in the shoulder. These provings of the power of ranunculus to cause musculo-neuralgic pains in the chest walls are amply verified by the experience of homœopaths in practice.—*Ibid.*

ACTION OF RANUNCULUS ON THE SKIN.—The action of ranunculus on the skin is remarkable and quite unique, and it constitutes with the rheumatico-neuralgic pains an important and interesting sphere of action, a good deal resembling rhus. To give a clear idea of the effects of the plant on the skin, I must quote the proving entire: "In the first quarter of an hour the powdered bulbs when applied to the fingers cause an itching of the same, which is always followed by a blister, even if the skin should not be changed. On applying a piece of the bulb between the fingers, a burning was experienced after the lapse of two minutes, which soon ceased after the removal of the bulb; after the lapse of two hours, the place became red, and in ten hours a blister was formed, emitting a large quantity of thin yellowish burning fluid. Vesicles on the fingers, especially those of the right hand, as if caused by a burn or a blister; after being opened with a pin so that the skin of the blister was preserved, they emitted for eight days a yellowish lymph with burning pains, the bright red skin showing through the blister. After the blisters had been healed for a fortnight, and the new skin which had been excoriated had likewise healed again, small, deep, transparent, dark blue, little elevated blisters of the size of an ordinary pin's head, are formed (as if the pores were raised in the shape of blue, transparent vesicles); they are crowded together in oval-shaped groups the size of a shilling, with intolerable burning, itching; when these vesicles are opened they emit a dark yellow lymph, and afterwards become covered with a herpetic horny scurf, itching intolerably, and emitting a clear fluid when scratched, or even of itself. After the horny scurf which had formed after the vesicles had been scratched open had crumbled away of itself within eight or ten days, new blue vesicles appeared again, with intolerable burning, itching, inducing frequent scratching; the scratching brought on a shining red loose swelling of the fingers, with inflammation and intolerable burning, stinging, itching. On applying hart's grease to the swollen fingers to suppress the itching, the horny scurf no longer formed, but in places the size of a shilling, crowded groups of small holes of the size of a pin's head (as if they were pores) were formed, emitting a yellow lymph in the shape of drops of sweat, and changing to small, flat, spreading ulcers, healing with difficulty, with corroded sharp borders, and intolerable burning, stinging, itching, depriving him of rest for weeks, day and night. The affection described in the latter part of the symptom came on a fortnight after the vesicles on the fingers, caused by the juice while expressing it had been healed; first the affection appeared on the index and middle fingers, which had been covered with vesicles by being touched by the juice, and afterwards it spread from finger to finger and from hand to hand, although no vesicles had existed on these parts."

This remarkable proving indicated ranunculus as a remedy in herpes, and herpes zoster particularly, and in this its virtue in allaying pain and itching irritation has been frequently proved. It would also be indicated in vesicular erysipelas, and in vesicular and pustular eruptions attended by much itching, while it might be of service in nettle-rash, and relieving the itching of nettle or bee-sting used well diluted.—*Ibid.*

APIS—AN INVOLUNTARY PROVING.—A bee stung me on the helix of my left ear one hot June day. I give the symptoms in the order of their sequence, as far as the

brain remained clear enough to note them. 1. Sensation as though a large stick like a broom handle were thrust through my head from left to right. 2. Swelling of the entire person. 3. Eruption like a nettle-rash covering the entire surface, even the palms of the hands and the soles of the feet. 4. Severe nervous chill, with chattering of teeth and shivering, but without sensation of cold. 5. Complete suppression of urine with pain in the kidneys and bladder. 6. Dull pain in the entire head, with sensation of weariness of the brain, and a stupid condition with inability to note symptoms further. (At this juncture my husband administered a gill of Holland gin. I had taken a sponge bath of ammonia and water. Was placed in bed.) Secondary symptoms: After a restless sleep noted the following conditions: 1. Retention of urine, followed after a few hours by a scanty discharge of red, hot urine. Pain and soreness in the region of the kidneys, bladder, and ovaries. 2. Eruption disappeared, leaving the skin, white, waxy, and a condition of general oedema. 3. Extreme sensitiveness to touch and soreness on deep pressure. 4. Brain symptoms slowly relieved. 5. Soreness of muscles, and stiffness of joints like rheumatism. At the end of a week was restored to normal condition.—Julia C. Jump, M. D., in the *North American Journ. of Homœopathy*, May, 1893.

SARSAPARILLA IN GONORRHOÆAL RHEUMATISM.—A male, aged about 40 years. By profession a milk-man. He had to look after all his household affairs and had to be exposed to the rain and sun for the execution of his business. About a month hence he was attacked with pains in his left knee joint, accompanied with some swelling. After a fortnight his state was lamentable, as both his legs were affected and he could not stand upright; it would not be amiss to say that he could not even stretch his legs. He sent for me; when I went to see him I found him in the above state. I prescribed *rhux tox.*, 30x, considering it simple rheumatism, but after four days I found his state was similar to that seen by me on my first visit; then I inquired of him whether he was suffering from an attack of gonorrhœa; he said he was, and I represcribed sarsaparilla, 3x, one drop, thrice daily, for a couple of days, and all his pains abated and he is now quite fit to look after his affairs.—Dr. Adhar Chandra Sanriji, in the *N. A. Journ. of Homœopathy*, May, 1893.

SARSAPARILLA IN SYPHILIS.—A gentleman, aged about 55 years, by profession a native physician (Hakim). He acquired the above malady by his profession as he had to examine some of the cases of self-acquired syphilis for treatment previous to his own attack. The hakim was quite unfamiliar with the contagious nature of the disease, therefore, he had not even washed his own hands after the examination of the cases. Hence, I diagnosed his case as not self-acquired, simply a secondary one. The following symptoms were presented: Inflammation of the male generative organ, corroding ulcers on the top of it and underneath the flap; urinary difficulty; such as urine mixed with pus, burning sensation at the time of passing water. When I went to see him I found the above symptoms and I prescribed internally sarsaparilla, 3x, one drop every two hours, and externally application of carbolic oil, proportion 1-20, after cleansing those ulcerated parts with tepid nim-water.* After a fortnight his urinating difficulty was removed, ulcers dried up and the inflammation subsided.—*Ibid.*

TREATMENT OF TUBERCULOSIS OF THE TESTICLE BY LANNELONGUE'S METHOD.—Ozenne presented a man of 31 years to the Paris Academy of Medicine whom he had successfully treated by Lannelongue's sclerogenic method, for tuberculosis of the testicle, epididymis and cord. In six sittings, after a preliminary injection of morphine, seven injections of the chloride of zinc (1-10), of two drops each, produced a great improvement. After a subacute attack of orchitis, the nodosities and infiltration had disappeared, and his general health improved. This had persisted for six months, and hence he recommends its trial, in tuberculosis of the testicle, epididymis, vas deferens, prostate gland and seminal vesicles, instead of radical surgical measures.—*Le Progrès Medical*.

AVENA SATIVA IN NERVOUS DEPRESSION.—Dr. Goullon relates the case of an elderly maiden lady, who had been greatly reduced in consequence of a rheumatic affection, and who was inclined to nervousness. The disease had attacked her knee, and kept her several days in bed. Her strength was reduced, and she was depressed and pessimistic. *Rhus* and *chininum* had no tonic effect. Two drops of *avena sativa*, three times a day, were given. In a few days her entire mental state was changed for the better, for she was happy and greatly improved.—*Allgemeine Homœopathische Zeitung*, Nos. 1 and 2, 1893.

* The *Azadirachta indica*.—[Eds. H. M.]

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THE MATERIA MEDICA AND MODERN RESEARCH.

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(Illustrated by the Pathogenesis of *Coccus Cacti*.)

THE enthusiasm of the founders of our system of medicine doubtless led them into extremes. It would seem that when a new and important truth is perceived by the mind, its perception is apt to produce a state of mental perturbation that tends to warp the judgment and to throw things out of their proper relations to one another. Men call this state of mind enthusiasm and there are few who are free from its influence, although some are much more subject to it than others. Enthusiasm is a quality better suited to propagandism than to scientific investigation. The scientist must first discover, and then the enthusiast makes the discovery known and by his confidence and magnetic influence over other minds, convinces them of the truth and makes them his disciples. Time passes and others inherit the knowledge of the truth, but these have not the enthusiasm of those to whom it was revealed. There is more science than enthusiasm in their composition; the influences that accompanied the discovery are less strong, and the result is that the revelation receives a second and more critical examination, during the course of which all superfluities are excised and only the simple truth remains.

It has been thus with homœopathy. In Hahnemann were united the scientist and the enthusiast, and the truth which he brought to the attention of the world has descended to us not entirely free from the effects of early enthusiasm. The time has arrived, however, when all truths, or such as have been held as truths, are being subjected to the closest scientific scrutiny, and among these are the truths of homœopathy. So far it appears that nothing has been discovered that tends to weaken confidence in the *law of similars*, the *single remedy*, the *minimum dose* and the *importance of testing or proving drugs upon the healthy*. The theory of psora has been swept away or so altered as to be practically a new statement; the belief in exceeding high dilutions—a device of Hahnemann's disciples—is rapidly losing ground; while the crude ideas of pathology current a century ago are now no longer credited. The central idea, the keystone of homœopathy, is the law of similars, and the truth of this law is only more clearly brought out in the crucial examination of the present. Like the diamond it shines with the more brilliancy the more light is thrown upon it. Much study has been devoted recently to materia medica with the aim of ascertaining the actual effects of drugs upon the human system. Many have dreaded the results of such investigation thinking that the materia medica would be weakened by the elimination of well-known symptoms which had often guided them in the selection of the remedy in cases of disease. It may therefore be of interest and perhaps of value to endeavor to ascertain how the materia medica is affected by the application of modern methods of scientific research.

In order to possess what is termed materia medica it is necessary unless compiled empirically, to test drugs upon healthy human beings. The question at once arises, do all drugs produce symptoms when so tested that may be utilized in the treatment of disease? The answer to this query may be found in any work on materia medica. Open Hering or Allen to any drug, one by preference not too well-known, *coccus cacti*, for example. Here is a drug whose medicinal powers were ignored, if known, until it was tested upon the healthy; yet it now appears that Allen records 1018 evidences of disturbed vital action, and in the revised pathogenesis of *coccus cacti*, recently completed by the Medical Investigation Club, of Baltimore, in which all unreliable symptoms are eliminated, there are still 151 symptoms recorded. Upon investigation it appears that decided effects are produced in testing in this way many other substances, and further, that proving upon the healthy beings brings to light

remedial powers otherwise unsuspected. The pathogenesis of *coccus cacti* also illustrates this point. Cochineal is looked upon generally as a harmless dye and often used to color ices and confectionery ; no one would be apt to attribute to it medicinal properties. Test it upon the well, however, and it gives evidence of strongly affecting the system.

Glance over the symptomatology and note its effects upon the system, bearing in mind that the small figures or exponents indicate in how many of the nineteen persons on whom the drug was proven, each symptom occurred.

Restlessness³.

Feeling of prostration⁵.

Irritable mood⁴.

Headache¹¹, character of pain : pressive⁵, shooting³ (in left temples³). Location of pain : frontal⁴, in temple⁵.

Pain in the eye³.

Tongue coated³.

Increased flow of saliva⁴.

Taste : sweetish⁴, bitter⁵, metallic⁶, pappy³, disgusting³.

"Sore throat³."

Feeling of roughness in the throat⁶.

Appetite diminished⁶.

Pain in the stomach⁴.

Pain in the abdomen¹² : griping⁵, cutting³.

Diarrhoea⁵ : pappy³, copious³, with griping³.

Pain in the bladder⁴.

Burning in the urethra while urinating³.

Increased sexual desire⁵.

Pain in the chest⁸.

Pulse accelerated³.

Pain in the neck⁵; back⁹; arms⁷; legs⁶.

Chilliness⁴. Dry heat².

Chilliness in the day, followed by profuse sweat towards next morning².

It would appear from a study of the above partial symptomatology of *coccus cacti* that testing upon the healthy is a valuable means of ascertaining in what way any drug affects the human system, for it seems evident that if an apparently inert substance like cochineal is capable of such a decided influence on vital processes as is indicated in its pathogenesis, so much the more will those

substances which, like arsenic or mercury, are recognized medicines.

We have now ascertained how to discover in what way medicinal substances affect the system, or, in other words, what symptoms a drug will produce. The next question that will arise is, Will the drug cure a disease which exhibits a set of symptoms similar to those produced on individuals during its proving? To answer this, recourse must be had to experiment and the experience which results from repeated experimentation. Some one may say, at this point, that all this was settled by Hahnemann long ago, but the answer to this is, that one must find out these facts for himself in order to be thoroughly established on solid ground.

Let us now recur to *coccus cacti*. While this remedy is, judging by its symptomatology, evidently adapted to give relief in prosopalgia, muscular rheumatism, and affections of the urinary organs, its greatest usefulness would seem to be in the treatment of pertussis, as it presents a group of symptoms bearing close resemblance to this disease, as may be seen in the following rubric:

RESPIRATORY ORGANS.

Irritation in the larynx, which causes coughing⁶.

Hoarseness⁹.

Irritation in the trachea⁵.

Painful sensations in the lungs³.

Cough¹²: caused by persistent irritation in the bronchi²; short cough⁵; dry⁶; frequent⁵; in short paroxysms⁴; disturbing sleep at night³; tending to cause vomiting².

Expectoration⁸: easy and in large amount¹, *viscid and clinging*²; yellow³; in grayish lumps¹.

Dyspnoea³.

Now, if cases of pertussis are improved by *coccus cacti*, if the violence of the paroxysm is lessened and the duration of the disease shortened, may it not be considered proven that, so far at least as this one drug is concerned, the law of similars is a reliable and practical guide to the selection of a remedy. Every physician who may read this paper has it in his power to answer this question for himself out of his own experience, and it is good evidence that Dr. Farrington gives on this point in his *Clinical Materia Medica* (p. 31), in which book he, being dead, yet speaketh.

For myself, it may be said that *coccus cacti* has given great relief

in many cases of whooping-cough. A number of these cases could be cited in detail, but this does not seem necessary. Its employment has been attended with such success, however, that it is at present my chief reliance in this obstinate affection. The most convenient and useful preparation is the second decimal trituration, in tablet form, it being easily administered thus to the youngest child.

It may be concluded, then, that testing drugs on the healthy evolves valuable results, which, through the application of the law of similars, may lead to the successful employment of these drugs in the cure of disease. It is also evident that revision of the *materia medica*, when carefully conducted, does not take from its strength, but adds decidedly to its virility and usefulness.

ARBORIVITAL MEDICINE.

BEING AN INQUIRY INTO THE CURATIVE POWERS OF SOME OF
OUR COMMON FIELD AND GARDEN PLANTS, JUDGED
OF BY THE DISEASES OF THE EAR.

BY ROBERT T. COOPER, M.A., M.D., LONDON,

Physician, Diseases of the Ear, London Homœopathic Hospital.

(Continued from March, 1893.)

BEFORE going on to other remedies, it may be well to review a few additional clinical experiences with the bluebell of the woods, the *agrophis nutans* or *scilla nutans* as it is sometimes termed. As aggravation, a pain in the right side of the abdomen, apparently in the *quadratus lumborum* muscle and which had come on from a chill, and which was aggravated by raising the arm or jerking, became much worse all the evening after φA , and then gradually went away leaving only a fulness behind and causing the bowels to act more freely (in a woman of 55).

It is when we come to the symptom, deafness, that the striking advantage of giving a single dose at a time is apparent. There is being treated at a distance, a poor lad of seventeen, who had been deaf from childhood and was unable to earn a living from deafness, the membranes being anæmic and the hearing distance only barely

off contact on both sides, in whom improvement began at once after *agraph. nut. φ A*; though my sheet-anchor in such cases, *calcareo carb. 200* and *calendula offic.* had both failed.

There were no symptoms beyond that he was stated to hear better in a noise, was worse in damp weather and had tumefied tonsils. There has been no opportunity of testing the watch-hearing.

Here is another case that shows how directly the *agraph.* acts on the ears :

C. G., a light-haired fairly healthy looking little girl of five, had been deaf for six months, the deafness having followed upon a severe attack of measles complicated with pneumonia. Deafness in both ears with stuffiness of nose and pains in ears when she blows nose or sneezes, unable to hear watch with either ear. (N. B. The testimony of a child so young is doubtful.) Absolutely no other symptoms. On Saturday, January 28th, *agraph. nut. φ A*.

February 11th.—On the Sunday after being here, had a burning sensation in her nose for half a minute, and now there is no pain on blowing nose or sneezing. Hearing same, continue the *φ A*.

February 25th.—Very much improved, was sick in omnibus on leaving this the last day; no pain in nose but some irritation in ears. No medicine.

May 13th.—Continues to improve; had a pain in right ear on blowing nose a few days ago, but no irritation in ears. Hearing distance, 20 in. on both sides.

May 27th—Hearing seems all right, tongue rather coated. Hearing distance, R. 40 in.; L. 50. Given another dose.

In the last case the membranes were perfect, but in this that follows large perforations existed on both sides.

Ellen H., *æt.* 9, deaf 3 years from measles, subject to psoriasis, marked over both knees; no symptoms beyond snoring at night (from large tonsils) and a feeling of shaking in the head at times, H. D., R. 3, L. 4 in.

Dec. 10th.—*Agraph. nut., φ A*.

Dec. 31st.—Again *agraph. n., φ A*. H. D., R. 4, L. 3.

Jan. 14th.—Same prescription. H. D., R. 6, L. 3½.

February 4th.—Continued improvement, R. 7 in., healed perforation, L. 10, discharging slightly. Psoriasis drying off. One dose again.

February 18th.—No medicine. H. D., R. 9, L. 15.

March 11th.—Psoriasis gone, only a few white scales left. Hears beautifully. H. D., R. 16, L. 23. Last attendance.

In this case complete recovery, for I have no doubt even the watch hearing went on improving, resulted from four single doses.

The disappearance of the psoriasis while under treatment may point to a special influence upon the skin.

In the early days of Homœopathy *scilla maritima* was much more used, and I feel, wisely so, than at present; whether it possesses the rich curative influence of *agraphis nut.*, can be ascertained only by the use of a tincture made from the growing scape and flower-bud and by the use of single doses. The bulbs of plants are the parts containing reserves of food material for sustaining plant-life, and as such may contain neutralizing ferments; ferments, that I hold, may interfere with the full and characteristic influence of the plant's growth-force.

In a man of 47, with numbness in both ears, three or four months, following upon rheumatics in head five months back, the numbness being caused by something filling up in the ears after he gets up in the morning—mucus, with a soreness and stuffy feeling in back of palate from mucus, with pains in the lower abdomen, lower back pains, and pains up the back of the neck, worse in the day-time, and much flatus, with deafness on both sides; patient described himself as altogether relieved by one dose, but as he neglected to attend a second time, no proof of cure is forthcoming.

In a man of 30 years of age with a history of gonorrhœa five or six years ago, *agraphis nut.*, φ A. was the only remedy out of several tried that improved, and on a second dose being given after some months' interval with other remedies, dispersed the following symptoms:

Seminal emissions for a week at a time, and then off for a fortnight or so; go on even in daytime; nerves much weakened, with inability to touch alcohol. Also catarrhal diarrhœa, small clear jelly motions after eating; irresistible, and preceded by sudden spasms in lower bowels, always worse when emissions are about, with pain and sweating of the lower part of the back; no bleeding nor any great straining.

In an old *embonpoint* bronchitic, emphysematous, asthmatic patient, who had suffered for years, a single dose of *agraphis nutans* has been followed, whether *propter hoc* or not, I am not prepared to say, with the most heavenly relief from attacks for the last eighteen months.

I shall next take up *viola odorata*.

AILANTHUS GLANDULOSA.**BY A. C. COWPERTHWAITTE, M.D., CHICAGO.**

(Read before the Hahnemann Medical Association of Iowa.)

THIS is one of the new remedies which, though not often indicated in disease, is one of our most useful remedies in a type of diseases which make it of intrinsic value when the indications are present.

The attention of the profession was first called to this drug by Dr. B. P. Wells of Brooklyn. His daughter, aged fifteen (15) years was suddenly seized with all the symptoms of the invasion of malignant scarlet fever. There was violent vomiting; severe headache; intolerance of light; dizziness; hot red face; inability to sit up; rapid small pulse; drowsiness and at the same time great restlessness; much anxiety. Two hours later the drowsiness had become insensibility with constant muttering delirium. She did not recognize the members of her family. She was now covered in patches with a red miliary rash and efflorescence between its points, all of a dark, almost livid color. The eruption was more profuse on the face and forehead than elsewhere. According to Dr. Wells's report, "It seemed that she could live but a few hours. Such cases in the practice of the writer had always progressed to the fatal termination; this had been more rapid in its progress than any I had ever seen."

The patient being his own child, he had an opportunity for most carefully watching the case. In about three hours from the first appearance of the eruption, the livid color began to lose something of its dark hue, the restlessness and anxiety diminished, the pulse became more distinct and less frequent, consciousness partly returned, the eruption became of a brighter red and the whole train of symptoms so similar to this pernicious form of fever, gradually gave place to a train of phenomena scarcely less marked but not at all like those of any variety of scarlet fever. Of course, this was not a case of scarlet fever, but after a short time it was a great puzzle as to what it could be or what could have produced it. These were questions not to be put aside and when consciousness had so far returned that questions could be intelligently answered, the nature and cause of the case remained no longer a matter of doubt. As the eruption

began to lose its dark hue and take on a bright red, there occurred a repetition of the series of symptoms which the doctor had recently treated in the case of a small boy who had been poisoned by eating the seeds of the ailanthus. This resemblance was quite a surprise and at once excited suspicion that this was a case of similar poisoning, and so it proved to be. This patient and one of her younger associates had been amusing themselves the evening previous to the attack by stripping the outside bark from the young and tender shoots of the ailanthus and then, after writing letters on the stalks with the point of a pin, the letters were moistened with saliva which was rubbed on them with the end of the finger. This was many times repeated and by this process the juices of the stalk were conveyed to the mouth in considerable quantities. Its taste was an intense bitter. Both of the experimenters were made ill with similar symptoms, but the symptoms were much less violent in the other child. It is a singular fact that this patient has been attacked by a similar miliary rash each year since this poisoning at the season of the blossoming of the ailanthus.

Dr. Wells concluded that we had a possible remedy for those frightful cases of scarlet fever which prove fatal in the first stage with symptoms of cerebral intoxication, and many physicians in both this country and Europe have verified these suggestions.

It is further conceded, however, from practical administrations, that there must be in both the prover and patient a personal susceptibility to the action of the drug, as in many instances it has been known to produce no result whatever by the provers even in very large doses. This principle, however, is not peculiar to ailanthus as we find very many drugs having this same peculiarity. My own experience with ailanthus verifies these observations. The drug will not always act, even when best indicated so that it can be absolutely depended upon in all cases, but when it does act its action is so prompt and satisfactory, and occurring as it does in such low types of disease, where death seems almost certain, we cannot help considering the drug an invaluable remedy. We may say in proof that ailanthus acts directly upon the brain and cerebro-spinal centres, produces low adynamic pains greatly simulating the malignant forms of scarlet fever. It also has an especial affinity for the skin, giving an eruption similar to that of the various repetition of fevers. Its therapeutic indications may be very perfectly summed up in the following characteristics: "Symptoms; malignant scarlatina and other low adynamic forms of disease characterized by sudden and extreme

prostration, constant vomiting and the purplish appearance of the skin."

I think if those present will give this drug a trial when these symptoms are present, no matter whether they have a scarlet fever, a typhus fever, or cerebro-spinal meningitis, or even a dysentery, or in fact, any low form of disease with these characteristics, that they will be very well satisfied with the results.

A PLEA FOR EARLY OPERATION IN DIPHTHERITIC CROUP.

BY R. K. VALENTINE, M.D., BROOKLYN, N.Y.

(Read before the Kings County Homœopathic Medical Society, June 13, 1893.)

THE enormous death-rate from diphtheria is doubtless in great part due to the stealthy method of its approach. Even intelligent parents are thereby frequently deceived, considering their children's indisposition due to acute indigestion, fatigue from over-exertion, as after play, or anything but that fatal malady, unless, perchance, the little ones complain of sore throat. The family physician, therefore, is not summoned until the toxic symptoms are more or less pronounced. Some of the most disastrous cases it has been either our good or bad fortune to meet with have started up in just this way, having in the beginning no subjective throat symptoms whatever, which made the little patient complain of pain, or in those too young to talk, that would direct one's attention to the throat. Further reference to the beginning of such an attack I will not make, except to say that the temperature which runs up to 103 or 104 or higher, at the commencement, usually subsides after three or four days, and if the child recovers on the seventh, eighth, or ninth day, the elevation of temperature does not usually recur. If the child does not show marked signs of improvement by the eighth or ninth day, and especially if by this time there has been an encroachment in the laryngeal mucous membrane, then and from now on the elevation of temperature becomes a very important factor, and must be constantly referred to in conjunction with the other symptoms which are bound to appear. The complication of the laryngeal mucous membrane can in no way be foretold by the deposit present in the pharynx. The latter may be almost completely filled with membrane and disorganized epithelial tissue, yet the case will clear up

without a sign of extension up the posterior nares or down the wind-pipe. In another instance the amount of deposit has materially lessened in the pharynx, but a few coughs of our little sufferer will signify our next field of battle. This cough has not usually a croupy sound in the very beginning, but resembles a catarrhal laryngitis. In a few hours, however, towards the latter part of the day or at night, the characteristic hoarse sound develops, and he who has fought with even one such case knows pretty well just what is to follow.

Let us briefly examine the minute anatomy of the lung.* The smallest bronchial tubes divide in the lobule from four to nine times until they reach a diameter of about one-fiftieth of an inch. Towards their termination little bulgings appear which are the air cells or pulmonary vessels, and they become more numerous until the whole extremity of the tube is made up of them, and they are arranged in the form of an inverted funnel with the base towards the surface. These air cells are separated from each other by prominent septa and are about one one-hundredth of an inch in diameter in the adult, and one two-hundredths of an inch in the infant. They are largest over the surface, at the thin borders and in the apices of the lungs. The areolar and elastic-tissue of the bronchiole go to make up the walls of the air cells by an interlacement of their fibres. The muscular coat is absent. The mucous membrane is very delicate, and covered with a squamous epithelium, thus changing from the columnar ciliated of the bronchial tubes. The capillary network, which is what I particularly wish to call your attention to, commences around each cell, as circular arteries, having a diameter of from one-twelve hundred and seventieth to one-eight hundred and fortieth of an inch, and from these are given off the plexuses which line the air cells, and run up over the septa between them. The diameter of these vessels is from one twenty-five hundredth to one three-thousandth of an inch, and the inter-spaces are but little, if any, wider, than the arteries themselves. Nor is this all the supply of blood through these delicate structures. Branches of the pulmonary arteries also accompany the bronchial tubes, and terminate on the outside of the air cells and bronchia in a delicate network of anastomosing vessels. The bronchial arteries from one to three in number to each lung, arising from the aorta or intercostal arteries, supply the lung structures, pleura, bronchial tubes, and glands, and

* Quain's *Anatomy*.

the coats of the larger vessels in the thorax. Referring to the bronchial branches in particular, they form a fine network beneath the mucous membrane throughout the bronchial tubes and terminate finally in the pulmonary capillary system.

Now I ask you to pause for a moment and consider what effect a stenosis of the larynx must necessarily have on these exquisitely fine structures with their enormous blood supply. Each inhalation produces more or less of a vacuum in the chest, to fill which inflows the blood over-distending the thin walled capillaries of the portal circulation, as well as the arteries supplying the lung structures, and as the little sufferer makes on an average from twenty to thirty-five respirations a minute, only think of the degree of congestion maintained in these delicate vessels, not only for hours, but frequently for days. Is it strange that a diffuse broncho-pneumonia ultimately develops in a large proportion of cases? We think not. And from the fact that it is diffuse makes it far more serious than are many cases of the original disease. From my personal experience with diphtheritic croup I feel safe in saying that there is a time in no disease when it is more necessary to have a positive knowledge of just when to operate to save life than just here, and yet there are but two rules which seem to be pretty generally known by physicians, and to which the majority seem willing to cling without questioning their real value, thus throwing all their experience of years in examining chests aside, and remaining passive in the presence of a little one developing such a pneumonia, waiting, and what for? Firstly, because the patient *seems* to be getting air enough, and secondly, and what to my mind, is still more censurable because the epigastrium does not sink in with each inhalation. If the operations for the relief of this awful congestion were at all serious, then there might be some excuse for making them a last resort, and permitting our patients to venture a little nearer an almost hopeless complication, but as intubation and tracheotomy rank among the least fatal surgical procedures, the danger of either one of them as against a broncho-pneumonia should count as nothing. Yes, we admit the child may seem to be getting air enough, but what injury may one hour after another of such forcible breathing be producing within the chest? Again, regarding the second rule we maintain that frequently when the sinking in of the epigastrium is observed the trouble which the operation was intended to ward off is already seated. This we will venture to say will be proved, not only by the chest sounds, but the temperature which will probably range be-

tween 104 and 106. The one condition which makes a physician doubt his diagnosis of an impending broncho-pneumonia at this time is doubtless the transmission more or less extensively over the chest, of sounds from the mucous râles located in the larynx and drawn back and forth with each respiration. To get clear of these and be able to form an idea of the degree of stenosis we would suggest applying a stethoscope to the back of the neck opposite the larynx, and thus in its transmission through the spinal column the sound produced by the stenosis will be heard distinctly above that produced by the mucous rattling. The simple rules which I shall follow in the future with these little patients are these: if there is a distinct laryngeal stenosis; a pronounced sirking in of the supra-sternal fossa; no *clear* vesicular murmur heard over the lower lobes of the lungs; a bronchial breathing through the region of the middle lobes and sub-crepitant râles also heard here, immediately after the laryngeal râles have been coughed up, or driven away from the vocal cord, as they frequently are by the act of crying. Indeed, the chest sounds resulting from an engorgement of this wonderful capillary circulation remind one of an œdema of the lungs, except for the absence of the large and very fluid bronchial râles usually observed in the latter condition. Lastly, if together with the foregoing symptoms, the temperature be about 103, then intubate, whether the patient *appears* to be getting enough air or not. To be sure we recognize the fact that there are cases of diphtheria in which the lungs are at first attacked, but these are very rare and were they not, the history of such attacks up to the condition of a chest presenting the symptoms just described, is vastly different. I believe it would be impossible for any physician to see a patient for the first time, having a condition of chest just described, and say positively whether the symptoms were due simply to a very severe congestion of the vessels all through the lungs, or whether together with this congestion there was a beginning deposit of membrane along the bronchial tubes and in the air cells. The history of the attack from those around the patient should start one on the right track, however, and learning from this history that the stenosis has persisted for some time and gradually grown more severe, an operation is imperative, and no surmise which can be proved true only by a post-mortem should be permitted to dissuade the operator from making it.

Bacteriologists tell us, and doubtless truly, that diphtheria is a toxæmia, the bacilli not entering the blood but multiplying very rapidly within, and especially in the deeper layer of the pseudo-

membrane where the poison is generated. From these local points it is absorbed into the system and produces the degenerative changes in the nervous system and tissues generally, which you all know so well. They also tell us regarding pathogenic germs generally, that they vary greatly in regard to the intensity of their toxic principles, and that thus it is we have light and severe cases. In so many of my patients has the disease been advanced to an unmistakable toxæmia before the parents suspected the trouble that I have at last adopted the plan of having the throats of all children under my care examined once in forty-eight hours, well or sick.

It was not my plan to suggest any line of medical treatment whatever in this paper, and will consequently only say this, that if the child has been operated on, either early or late in the disease, and a marked condition of congestion is present, it would be wise to envelop the chest in cotton batting and prescribe a medicine likely to be indicated in the congestive stage of broncho-pneumonia.

A concise review of the points made in this paper are:

a. As soon as the laryngeal mucous membrane becomes involved, examine the chest frequently, and when the signs point to a marked congestion of the lungs, and the temperature of the patient is rising gradually, when it reaches about 103, intubate, unless there is good reason for making a tracheotomy.

b. When the signs of a broncho-pneumonia have preceded the laryngeal stenosis (and such patients would be likely to show a marked toxæmia), no operation would be indicated.

c. Intubation and tracheotomy are among the least fatal surgical procedures, and should not be considered a last resort, and because they are so considered by a majority of operators is doubtless why so many children succumb to a diffuse broncho-pneumonia.

d. A careful examination of the chest will readily signify a degree of marked congestion of the lungs, and the symptoms, "the child is getting air enough" or "the epigastrium does not sink in with each inhalation," are exceedingly crude, and the operator who waits without examining the chest while the first symptom apparently exists, and then still waits on for the second symptom to develop, frequently waits too long. In proof of which how often we have heard the expression, "the child was operated too late." I have yet to learn of a well-authenticated case where the child was operated by one or the other methods too early, and where bad results were traceable to the operation.

TREATMENT OF CLUB-FOOT.

BY CHARLES LESLIE RUMSEY, A.M., M.D., BALTIMORE, MD.

CHAUVISSER of Paris made investigations to ascertain what proportion of the human race was born deformed and he recorded the fact that one hundred and thirty-two out of twenty-three thousand infants were thus born. Other observers have noted similar facts indicating, so far as the actual conformation is concerned, that Nature gives her children abundant opportunity for perfect physiques.

One type of deformity which is prevalent, whether congenital or acquired, is "Club-Foot" or "Talipes" which manifests itself in different forms. Whatever surgery can do to correct this or other deformities, contributes much to the happiness of the race as physical defects operate to the great disadvantage of the possessor.

From Hagen's statistics in his *Ätiologie und Pathogenese des Klumpfusses*—*Ætiology and Pathology of Club-Foot*—I have made the following deductions: of cases of "Talipes" "acquired" 56.5 per cent. and "congenital" 43.5 per cent. The relative frequency may be thus expressed: "males," 54 per cent., and "females," 46 per cent.; "single club-foot," 51.8 per cent., and "double-sided," 48.2 per cent. In studying the statistics of the principal orthopædic clinics in Europe, I observed, in this department of deformity, 61 per cent. "acquired" and in all its types the percentage is higher for "males" and double the number of cases is the "single-foot."

It was my privilege to witness a variety and number of such deformities in the orthopædic clinics of Prof. Wolff of Berlin and Prof. Lorenz of Vienna. Let me convey to my readers the impressions thus made upon me in the treatment of "Talipes."

To successfully treat any variety of "Club-Foot," we must consider the cause and the proper principles on which the treatment is founded. Determine, by careful investigation, whether the cause be paralysis of the muscles, spasm of the muscles, traumatism or static influences. The congenital variety may be hereditary and frequently associated with other congenital malformations as "Spina Bifida," "Syndactylus," etc.

Every case of "Talipes," congenital or acquired, is dependent upon the abnormal shape of the foot-skeleton. Any change of the soft parts is a secondary consideration.

Volkman and Hueter stated the alteration in the form of the bone was due to atrophy from pressure and growth in the direction of least resistance. Julius Wolff in his *Gesetz der Transformation der Knochen* (Berlin, 1892)—Law of the Transformation of Bones—states almost the contrary; he has shown the internal architecture and external form of every bone correspond with one another and are expressions of static demand made upon it. Bones are as capable of accommodating themselves to different changes as the tissues. To illustrate: at Prof. Wolff's Clinic on May 21, 1892, a patient with a hump on the dorsum pedis produced by the correction of a club-foot was relieved by maintaining the acting forces (weight of the body) upon the bones of the foot in their absolute normal juxtaposition.

The following principles for treatment of this trouble are urged by Prof. Julius Wolff:

First.—To bring the foot in a normal relation to the rest of the extremity and the body.

Second.—To retain such position by functional activity a sufficient period of time to enable the bones to undergo the necessary metamorphosis as a result of their function.

In Europe, the *technique* of plaster-dressings for club-foot are either Wolff's or König's with a surgeon's modification. The chief difference between the two is the forcible re-dressment. König advocates the bending or even breaking of bones and tearing of ligaments. Wolff opposes this.

König's Method.—The patient is anæsthetized and placed on his side. An assistant holds the knee firmly and the operator supports the most convex portion of the foot upon a well protected wooden fulcrum with one hand holding the interior portion of the foot from the inner side, and the other the heel and ankle-joint, using the weight of his body to forcibly correct the deformity. According to König, the operator must feel or hear a crackling sound. If there is a solution of the skin, it should be immediately sewed.

The patient should now lie on his back—the operator, with the one hand around the ankle-joint, forcibly brings the foot in dorsal flexion and abduction. If the case is difficult, let the entire correction occupy from two to four sittings at intervals of two or three weeks. If the case is very difficult, König recommends tenotomy and cutting of fascia before beginning this procedure. After each sitting plaster-dressing with a cotton stratum should be applied to hold the ground obtained by forcible re-dressment.

Wolff's Method.—The patient is anæsthetized, except in the case of very young children and slight degrees of deformity, and placed on his back upon a table. The middle of the patella is always marked by a blue-lead pencil. As in König's method, the operator seizes the anterior part of the foot with one hand and the other hand surrounds the heel. He then exerts his power in the reverse direction to the deformity and brings the heel towards the medium line, abducting the anterior part of the foot. Wolff never uses force sufficient to cause gross solutions of continuity of tissues and subluxation of bones. By maintaining the changed statical condition sufficiently long, the operator changes the bones in different relations to one another and to the extremity—the bones are changed by the changed function. The next step is considered by Wolff most important. The hands of the operator are replaced by those of the assistant to maintain the foot in its proper position. The operator now takes strips of adhesive-plaster, about one inch wide, and lays it on the upper surface of the foot close to its inner edge and posterior to the ball of the great-toe—then across the sole, up the outer side of the foot and a short distance up the leg with about three-quarters spiral around it. In like manner, a second strip is placed anterior to this. A third strip begins at the ball of the great-toe and a fourth runs along the base of the toes. Other strips may be added according to the judgment of the operator.

There should be a sagittal plane passing through the anterior superior spine of ilium, through the blue-pencil line in the patella and through the centre of the ankle-joint, which will be a few inches inside the end of the great-toe. The leg is now carefully raised by two assistants; one firmly fixing the knee, the other pressing the heel towards the middle line and abducting the foot. The foot and leg are padded with cotton as uniformly as possible. Pad well at the base of the great-toe and in front of the instep. If the skin is tender bathe the parts with alcohol and apply friction before the foot and leg are encased.

Bandages are applied over the dressings, allowing the toes to lie in a natural position; the dressings extend from the middle phalanges to the tibial tuberosity. Let it be remembered that all of the great-toe is included in the dressings as a necessary support. The assistants cautiously retain the leg in the position above described, till the Plaster-of-Paris is firmly set. As a matter of routine two fenestra are now cut in the dressings; the external surface of the ankle-joint and the metatarsophalangeal articulation of the great-toe (Fig. 2).

It is a fundamental principle of the treatment to cut out a fenestrum at any painful spot.

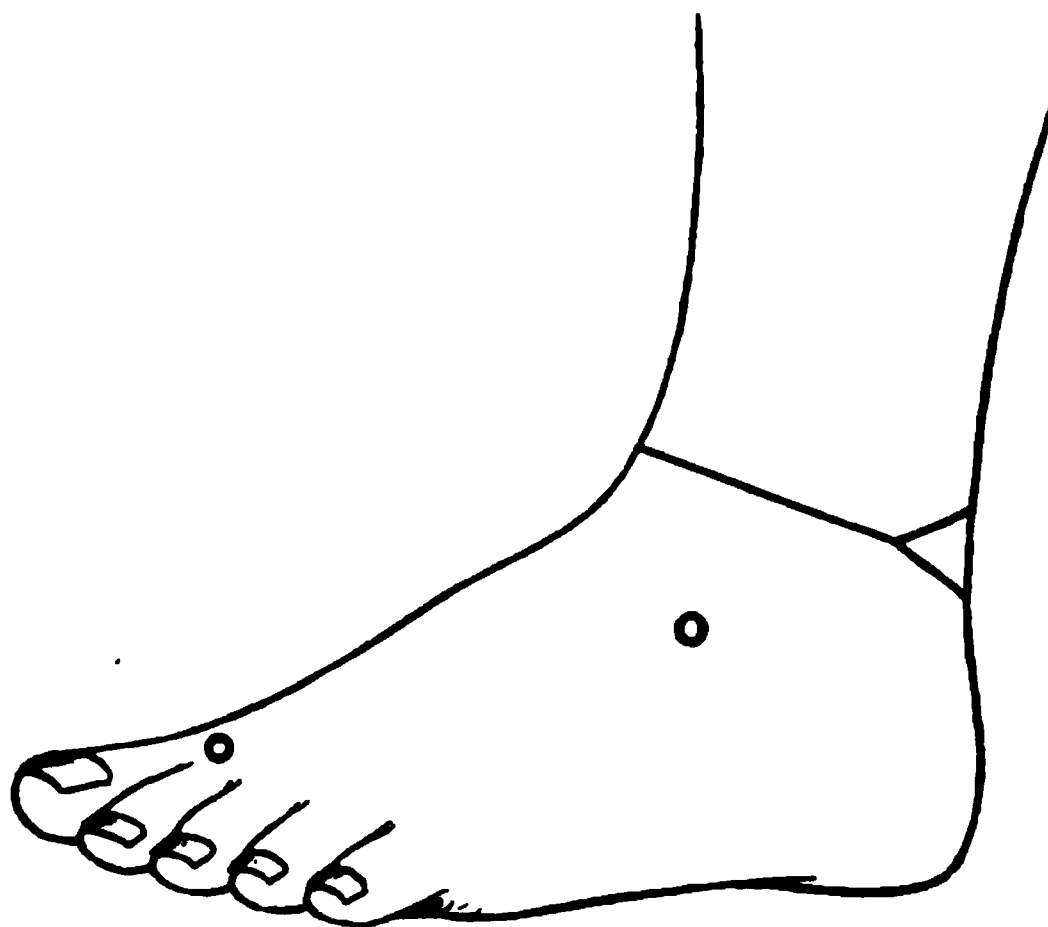
If the desired result is not secured on the first sitting, Wolff's "Etappenverband" is applied.

By this method a wedge-shape figure from the outer edge of the ankle-joint is cut from the dressings and the knife (Fig. 1) is continued around the joint (Fig. 2).



This defect in the dressing allows further correction without the foot returning to its original position, if the linear cut is not too close to the heel.

The sections of the plaster are drawn from one another *without allowing any motion of the leg and foot*, and the joint is strengthened by additional new dressings over the space thus made and the old dressing. Wolff repeats them at intervals of two or three days.



When the position of the foot is satisfactory, he scrapes away the unnecessary thick dressings and covers the fenestra with plaster-of-Paris. Strips of pine shavings are glued to the dressing to strengthen it and the strips are held by a crinoline bandage painted over with carpenter's glue. When the glue is hardened, a very light soluble glass bandage covers the dressing. The patient should have lace

shoes to fit over the dressing, and should be instructed to walk at once. The patient should be kept under supervision to make good any defect in the dressing.

In Wolff's Clinic, all cases of club-foot are successfully treated by this method with remarkable results, from the congenital "Talipes" of infants a few weeks old to that of adults of long standing. Wolff's patients stand in the dressings the day after the application, while by "König's Method" it is necessary to elevate the limb and to use precautions against swelling. The necessity for the use of Phelps's operation and tarsectomy, syndesmotomy, etc., for the cure of extreme cases of club-foot, is boldly denied by Wolff.

Lorenz bases his treatment of "Talipes" on Wolff's principles and methods. For the treatment of the variety "Pes Valgus," in applying plaster cast, Lorenz places the palm of his hand under the sole of the foot corresponding to Chopart's joint. An assistant holds the front part of the foot while the operator produces dorsal flexion and supination, to maintain which, Lorenz suggests placing something from the heel to the point within the shoe on the entire inner side of the shoe, which raises the inner arch.

The heel should be large and wide. Lorenz advises with the treatment the following exercise:

First. Let the patient stand barefoot with the toes inward and heel outward; lift and sink the heel, rotating the heel inward.

Second. Let the patient sit with extended legs directing the toes inward, and then making a rotary movement of the foot inward.

With marked spasms of the muscles, Lorenz urges an injection of a five per cent. solution of cocaine.

The London surgeons, however, successfully resort to operative interferences from the tenotomy to the more complex operation. Anatomical precision and extreme care to prevent entrance of air are requisite in order to perform successfully tenotomy. If suppuration ensues after tenotomy, the tendon becomes adherent to its sheath and fails to unite by the organization of cellular exudation.

The Parisian surgeons, on the other hand, use mostly manipulation and plaster-of-Paris dressing.

In concluding, let me state that the different methods, the plaster-of-Paris mode, the surgical procedures, the orthopædic appliances of a more or less complicated character, etc., employed for the treatment of club-foot, are numerous, and each of them has given satisfaction.

All surgeons regard the physiological after-treatment as highly

important. The methods advanced in our text-book consist in teaching the patient the proper use of the restored foot—active and passive exercises, massage, hot and cold sponging, faradization.

Professor Sayre has stated that you may determine tenotomy on the reflex irritability of the contracting muscles when the foot is placed in its proper position; if a spasm of the tense muscle exists under pressure, tenotomy is required.

Permit me to add, I do not deny the importance of the knife, but I regard it wiser to correct a rebellious deformity first by "Wolff's Method" with necessary tenotomy. If necessity dictates, the knife can then be used on the intractable "Talipes."

ALBUMINURIA IN CHILDREN.

BY HENRY C. ALDRICH, M.D., MINNEAPOLIS, MINN.

(Presented to the World's Congress of Homœopathic Physicians and Surgeons, Chicago, June, 1893.)

MR. PRESIDENT AND FELLOW-PRACTITIONERS: My line of thought, for some time past, has been turned rather persistently in the direction of albuminuria. At the present time, medical opinion appears to me to be in somewhat of a transition stage in regard to the pathology of diseases of the genito-urinary organs. A good many ancient (and allopathic) fallacies have been exposed and dropped, and we, the homœopathists, are building up newer views upon surer foundations; the process will be slow, it has hardly more than begun, for the problems to be solved are so very numerous.

I have endeavored to look at the subject of my paper in the light of present knowledge only, and not to go one step beyond what that state of knowledge would seem to justify. I have kept rigidly before my mind, too, the fact that childhood only, at the present time, is my sphere, and, as a consequence, I can only touch upon such points in the general pathology of albuminuria as are within the limits of this restriction. Albuminuria, we know, may be produced in children from a variety of different causes; the rarest causation, however, is I think, due to pressure on the renal veins, but let the causative agent be what it may, I believe albuminuria should always be viewed

with gravity. If I might occupy a few moments of time with a hasty review of the physiology of the kidneys, I should be glad, as I think it will freshen our memories and assist us in the discussion of this subject; a subject I am most anxious to have discussed, both here and now, for I am assured that a finer opportunity for eliciting important truths from a conflict of fair minds will never arise.

Physiology of the Kidneys.—Gaze with a retrospective eye, if you please, and we find that the membranous covering of the internal surface of the secretory cells of the kidney is really a true protective organ, keeping from the protoplasm of the cells any substance likely to interfere with their functions. We remember, too, that this membrane varies in its structure, and the variation is due to the degree of functional activity of the epithelium.

1. In conditions of repose, this membrane is homogeneous; in conditions of activity, it is peculiarly marked, having a quantity of clear streaks running through, and taking on the appearance of a structure formed of small straight rods, these being held together, or separated, by an intermediate substance of a clear fluid character. After some great functional excitation a remarkable change takes place; the collected urine detaches and pushes away this membrane from the protoplasm.

The products of the renal secretion collect within the epithelial cells in the form of liquid masses, having either a rounded or elongated appearance, and clear like the contents of the tubules. This fluid percolates through openings in the limiting membrane, sometimes breaking through the latter to gain the interior of the canaliculi, often detaching and carrying it away.

A great advance has been made in our study of ætiology, proven by the fact of our knowing that a micro-organismal factor exerts its most prominent pathological influences upon the kidneys.

Within the past year or two, some notable contributions have been made to the literature of this disease, notably that of Clifford Mitchell, whose able exposition of the relation of urinary analysis to dirt is of untold value; of Mannaberg, upon the relation of acute nephritis and the streptococci found in endocarditis.* In eleven cases of acute nephritis, Mannaberg found the urine to contain streptococci, which disappeared from the excretion with the disappearance of the symptoms of the disease. In patients affected by other maladies, and in healthy individuals, this micro-organism is not to be found, although searched for in a long series of urines. Mannaberg has cultivated this streptococcus in question, and separated

it by peculiarities in its cultivation from other varieties of streptococci. These do not appear to select the kidneys as an especial position for growth, they probably multiply in the blood and tissues generally, and in their escape through the renal structures produce their serious consequences.

2. This, undoubtedly, is a form of blood-poisoning specially involving the kidneys. As I before said, a great many old fallacies have been dropped; the trend of thought and study to-day is carrying us still further and further from the old lines of thought; views formerly held, are either passing into desuetude, or becoming very much restricted; causes of disease, formerly hardly conjectured, are being added to the list, and some factors of causation, such as exposure to dampness, cold, etc., are dropped out.

I might occupy your time by citing almost numberless cases, published both abroad and at home, by adherents of both schools, where there is no apparent causation of renal diseases from exposure to dampness or cold. I will merely cite from Letzerich. He observed a number of cases of renal inflammation due to a characteristic bacillus, from cultures of which he could reproduce nephritis in rabbits. The symptoms he found, in general, similar to those in other cases of nephritis, somewhat mild in form, but showing a predominance of gastric pneumonia.

He found the spleen apt to be swollen, with considerable fever, and often rapidly developing œdema and effusion into the serous cavities. The urine contained short straight or curved rods in large numbers. These symptoms finding no history of exposure to dampness or cold, make the suggestion of a micro-organism exceedingly relevant, especially so when taking into consideration the manner of onset, the involvement of the lungs, and the prostration accompanying the affection. The affection in question was found most commonly in children, and, in cases which came to post-mortem section, it was found that the bacilli developed only in the interstitial structure of the kidney; the spores were, however, found, generally throughout the body. At no previous time has the question of the infectious nature of the renal affection, known as Bright's disease been so forcibly placed before the profession, and there can be no doubt whatever as to the prominence which will hereafter be accorded to infectious influences in the production of the malady. An exceedingly interesting and instructive paper, published by Agnes Bluhm, upon the ætiology of Bright's disease, is based upon an analysis of 8442 cases, material derived from clinics during a period of five or

six years, and the vast majority of these cases were clearly traced to an infectious origin.

We find, to-day, a good many men in our own school, besides numbers of outsiders, who still pin their faith to a belief in the constant existence of albumin in normal urine. After having made a great number of carefully conducted examinations of normal urine, I feel compelled to place myself in opposition to them; the results of my experiments have proved most satisfactorily to my own mind that the presence of albumin is not characteristic of normal urine. There are some of us who argue, that small amounts occurring in normal urine tentatively, is of no significance, that it is only where it reaches any proportion that it should be seriously considered. I believe that the smallest possible amount should be viewed with gravity, and that, under any circumstances whatever, albuminuria means some fault of the epithelial covering of the glomerulæ. Probably Purdy's experience along these lines has been as large as any other man's.

A publication of his upon examinations of urine for life-insurance takes this position: "No applicant for life-insurance should be debarred on account of albuminuria, but the time has arrived for stamping out the idea so prevalent among the profession that the slighter traces of albumin in the urine are of no significance. It has been my experience during the past five years to make a large number of analyses of urine, from cases of all sorts, but never once have I met with a single case of albuminuria in which a microscopical examination did not discover some pathological condition of the kidney or uropoietic system sufficient to account for the symptom. Single examinations have not always returned me the foregoing result, but repeated searching has never failed to disclose pathological evidence, so I have arrived at this conclusion: there is positively no such thing as a physiological albuminuria. 'Physiological albuminuria,' however, is a term which has found so much favor with the profession generally that whatever the belief may be the term will in all probability remain in vogue. I believe that albuminuria is many times the product of an incomplete or pernicious digestion; the incomplete transformation of the albumin leads to the production of a relative albuminuria, and from this by very evident steps to a true albuminuria. So, too, the various toxic substances from a perverted digestion are brought to the kidneys, in their excretions producing a like train of events.

I think when we are testing for albumin we should select the

specimen of urine voided at the time when the patient is most fatigued; the amount of albumin, as we know, is greatly influenced by circumstances. Then should begin an exhaustive examination for casts, and if one fails to find them when they are actually present the result must be a serious error in diagnosis.

Since I have insisted upon the entire collection of urine voided within the twenty-four hours, my experiments have proven much more satisfactory to myself and beneficial to my patients. When searching for albumin I have the child exercise as vigorously as is prudent before voiding urine for examination, and where the case is doubtful I examine the urine of each micturition during some one period of twenty-four hours. I need hardly say that the commonest cause of albuminuria is due to Bright's disease; but I do consider it my duty to say that I believe a large proportion of the so-called "physiological or functional albuminurias" eventuate in this malady, unless treated before being allowed to endure for any length of time.

We are to-day familiar with the fact that nephritis is a disease common to childhood, arising most frequently after scarlatina or other blood poison. Formerly it was considered as one of the results of cold, dampness and drinking habits, its especial province the adult. The average of disease in childhood is acute, so the prognosis for nephritis as regards complete recovery is mostly good. As a mere matter of enumeration we are perfectly familiar with the symptoms of acute Bright's disease, the pallor, the vomiting, convulsions, cough, dropsy, a pulse that intermits, oppressed breathing, scanty urine, with a large percentage of albumin, but individual cases are of most interest just now.

Howard B., a boy, aged 10, was placed under my care. His previous history was good, except for an attack of typhoid fever some nine months previous. The boy was hardly to be called sick from the time of his recovery from the fever until placed under my care—at least for a greater part of the time. Ailing at times for two or three days together, causing great anxiety then, and again appearing to be, and insisting upon the fact, of his being perfectly well. There had been an occasional slight swelling of the lower limbs, a fact to which the mother attached no importance whatever. When I first saw him he was in bed and the swelling had been on the gradual increase. I found the lad in a condition of extensive anasarca, the action of the heart very irregular. The urine was only a few ounces in twenty-four hours. Sp. gr. 1024, full of albumin, and containing granular and hyaline casts. The boy during

all this time, a period of nine months of treatment, insisted that he was well. The sp. gr. of the urine rose as high as 1030, and for a period of eight months the albumin averaged throughout from a third to a sixth. From that time on it decreased from one-fifth to one twenty-fifth; within five or six days it disappeared entirely. I began treatment by restricting his diet, much to the boy's chagrin, keeping him to milk and water, jelly, bread and butter, sweet potatoes and peptonized milk toast. Digitalis, and later on ferrum continually, brought the boy around. Since that time he has remained well.

A somewhat interesting case of incontinence of the urine came under my care recently, the patient a girl six years of age. The previous history, according to the mother's statement, was one of perfect health. Application was made for admission to the public schools. The child could not gain admission until vaccinated. From that time on she was ailing, the entire body breaking out in sores. There was a discharge from the right ear, and back of the ear a superficial abscess. The urine at the time was dark and contained coloring matter, and was loaded with albumin. The child was suffering at the time from prolapsus uteri with leucorrhœa. I need hardly speak here of the two avenues for physical examination. There is but one way to treat such cases as the foregoing—by means of combined rectal and abdominal palpation. In the case of the child just mentioned the belly walls were both fat and distended, and there seemed a great possibility of considerable resistance being offered. It was important that the examination should be thorough, therefore I anesthetized at once. Indeed, I think it advisable in all such cases; the effects are rapid, the duration short and the resistance slight. The rectal touch is the most certain way of approaching tubes and ovaries to be questioned. This combined with palpation by the other hand per abdomen is greatly enhanced in value. Rectal and bimanual massage proved very effective in restoring the pelvic organs to their normal tone. This accomplished, the albumin, which heretofore had appeared with the greatest regularity, disappeared. No casts were discoverable. The altered condition of the urine I considered as due to the altered conditions of pressure in the renal circulation. The muscular tone of the patient was influenced considerably by a daily application of electricity. China proved very useful here. I had a favorable and uninterrupted action of the single prescription, of the single indicated remedy. This "Hahnemannian trio," I rejoice to say, speaks for itself without any trumpeting. We have been accused by the old-school men of

“never having discovered a single bacillus.” Shall we ever rally from the thrust, or dare to look a brother allopath in the face again after being told such a thing as this? And yet, who is specially benefited by knowing that a certain comma bacillus is found in this, or a rod-shaped one in another? We have a law that a particular medicine produces a definite result, and that one thing we have proven to be of more practical use than the natural history of all combined diseases could ever be. In cases of incontinence of the urine, treatment must be given with an eye to the cause, the principal causes being the various motor neuroses. A large number of such cases are exceedingly troublesome; when, however, there is irritability of the bladder, I believe belladonna will prove our friend in almost every instance. In such cases I believe we cannot lay too much stress upon massage of the bladder per rectum. It has given me most excellent results, together with a daily salt water bath, accompanied by a brief rubbing in the region of the spine; there must, too, in such cases be a careful consideration given to hygiene and diet, and last, but by no means least, attend to the psychical surroundings. This may on first thought appear overstrained and far-fetched. I make it a strong point simply because I have watched the effects on a nervous child, of a nurse thoroughly uncongenial. I have seen the same kind of thing obtain in the hospital, where children were away from home, everything strange and new; it must be unnecessary for me to say that “powerful emotions” bring an increase of albumin in the urine. And, believe me, you will experience unexpected results frequently if you turn your attention with vigor toward this one thing. I think, if I remember rightly, our own Dr. Mitchell lays considerable stress upon this. To my mind it is something to be strongly considered, whatever the malady may be. I was asked in preparing this paper to show the prophylactic properties of homœopathy in relation to my subject. I confess myself almost totally at a loss here. The causes of “albuminuria in children” are many, are unforeseen, and, it appears to me, quite impossible to treat of it prophylactically.

THE TREATMENT OF GONORRHOEA.—Gottschalk warmly recommends alumæ prepared by Heinz and Liebrecht. It is a safe, odorless, antiseptic astringent, easily soluble in water, and has the special merit of deep action without severe irritation. A five per cent. solution is the proper strength for intra-uterine treatment, and a one to two per cent. solution or pencil for urethral medication. He recommends ten to twenty per cent. solutions or ointments for treating condylomata.—*Centralblatt für Gynäkologie*, No. 8, 1893.

RHINOLOGY AND LARYNGOLOGY—AN INAUGURAL ADDRESS.

BY HORACE F. IVINS, M.D., PHILADELPHIA.

(Chairman of the Section of Rhinology and Laryngology of the World's Congress of Homœopathic Physicians and Surgeons.)

MR. PRESIDENT, LADIES, AND GENTLEMEN: As Chairman of the Section of Rhinology and Laryngology, it is my pleasant duty to pass in review some of the points marking the progress in these specialties within the past year or two. As it is, however, impossible to consider all of the advances made in this line, I take the liberty of indicating those which seem to me to offer the greatest advantage to us; in addition to which I have revived some points of sterling merit introduced years ago, but which have practically fallen into disuse.

Before proceeding with the various subjects, allow me to express my appreciation of the honor bestowed upon me in placing me at the head of this Section, and to return thanks to those who have been kind enough to comply with my request for essays, at the same time regretting that more of our foreign *confrères* have not responded in a practical way, although a number of them have been invited to do so.

Considering our subjects in the usual manner, I shall first take up those which belong to the nose, and proceed to the deeper tracts, touching but lightly any of the sections, leaving to you the heavier task of dealing with the details.

Physiology of the Nose.—The division of the nasal cavities into respiratory and functional, so long taught, has had a drawback in the experiments of Keyser and Paulsen. They used osmic acid on the heads of cadavers, having previously performed the powder-test on them. The conclusions justified by these experiments are, that, during inspiration in a normal nose, the bulk of the air passes along the septum, above the inferior turbinated body, describing a semi-circle in its course, and extending upward nearly to the roof of the nose.—*Archives of Otology*, January 1, 1891.

Epistaxis.—The origin of nasal hæmorrhage is now well fixed in a large majority of cases; while it was formerly believed that the bleeding point might be situated anywhere in the nasal fossæ, it is at present certain that few cases originate in other than the anterior

region (the vestibule), especially in the triangular cartilage at the entrance to Jacobson's organ. This origin gives much greater certainty of finding the bleeding point speedily, and of promptly arresting the hæmorrhage. The best means which recent research has brought to light are, the application to the bleeding spot of chromic acid, or, the cherry-red galvano-cautery point. The former method is far preferable, as it is less likely to be followed by return at a subsequent period. In fact, I have never seen a second hæmorrhage, from the same point, follow the careful application of the acid in a fresh saturated solution. On the other hand, the cautery may destroy too much tissue, resulting in subsequent secondary bleeding. To the general statement, that most hæmorrhages originate in the anterior portion of the nasal passages, one exception must be made, viz., that in ætheroma, especially in very old persons, bleeding more frequently originates in the upper portion of the canals, and is general, not being confined to one or two points. The remedies applicable to such cases are generally carbo. veg., crotales, lachesis, and hamamelis; in younger persons, I have found bryonia almost unfailing. I am pleased to note one great advancement in the treatment of epistaxis, namely, that few physicians now recommend the use of such styptics as perchloride of iron, for they often do considerable harm to the nasal passages, at times, resulting in intense inflammation, abscess formation, and loss of the function of smell. Another long stride in the direction of reform consists in the almost uniform rejection of the cumbersome, painful, often dangerous posterior plug, and the substitution of the simpler, more scientific measures proposed by Dr. A. A. Philip (*The British Med. Jour.*, July 18, 1891), and by Dr. W. W. Parker (*Med. Record*, October 4, 1890). The former uses what he calls his "umbrella plug." A piece of silk, thin cotton, etc., is pushed into the naso-pharynx, along the lower meatus, by means of a smooth stick, pencil, or probe, placed against the centre of the material used. When introduced, the edges and corners of the material will project from the nostril. The introducer is then withdrawn, and by it the top of the umbrella pouch is well filled with little pieces of cotton or lint. The introducer is then firmly held against the cotton, and the umbrella corners pulled upon until the mass tightly fills the choana. The remainder of the pouch should then be packed, and the outer portion tied, bag-like, with a string. When it is desired to remove the plug, open the bag and pick out the cotton. Dr. Parker takes fifteen threads of patent lint or large spool-thread, three or four inches long, doubles them upon

themselves, and ties a string six or eight inches long around the middle. By the aid of a probe, the centre of the thread is pushed along the floor of the canal to the posterior nares. The probe is then carefully removed and the nostrils plugged.

Relation of Nasal Stenosis to Ear Defects.—Although this subject has frequently been dwelt upon during the past few years, it does not, in general, receive the attention which its importance deserves; this not so much with reference to the deafness as to the tinnitus aurium, that *bête noir* of the aural surgeon. Many aurists claim that at least 70 per cent. of all cases of catarrhal deafness are due to difficult nasal respiration, and that the cure of the latter means alleviation of the former, so far as it is possible to relieve; some even discard the Politzer bag and Eustachian catheter for other than diagnostic purposes, claiming that they do harm, even when used with the greatest care. To this I cannot subscribe, as I have repeatedly seen marked and permanent relief from the use of middle-ear inflation, without relieving the considerable nasal obstruction; but when the latter is also accomplished, the results are vastly superior to those obtained without it. Especially is this true of tinnitus aurium, which, when dependent upon nasal stenosis, as occurs in about 50 per cent. of the cases in young subjects, is speedily relieved by reducing the obstruction.

Atrophic Rhinitis.—While internal remedies are the most essential features in the cure of this trying condition, it is possible to supplement their action by judicious local measures. Of these none, perhaps, has gained more prominence or met with better results than has ichthyol. This is generally used in a 5 per cent. solution, in fluid cosmoline or albolene, and either applied directly to the part, after thorough cleansing, or sprayed into the nose several times a day. The cotton tampons introduced by Gottstein some years ago not proving thoroughly satisfactory, I made use of glycerin-coated cotton pledgets, which answer a better purpose in that they more quickly excite a flow of mucus. The consequent dislodgement of the hardened crusts renders nasal respiration freer, relieves the pressure in the nasal region, as well as the resultant headache, and at the same time reduces to a minimum, the unpleasant odor. More recently others almost fill the nasal cavity with numerous small, dry cotton pledgets, thereby effecting the same result; but in my experience, acting much more slowly and causing much more annoyance to the patient. Another method of treatment which has undoubted merit consists in the application of various powders, espec-

ally aristol and iatrol, to the lining membrane. The internal remedy which has recently been brought into special prominence is theridion, so long applied by Dr. A. Korndorfer, of Philadelphia, for the following symptoms: discharge yellow or greenish-yellow, thick, and offensive; but particularly if the crusts be drawn into the throat and expectorated. Dr. Korndorfer's chief symptoms are: offensive discharges (either thick or thin), headache, and a feeling of fulness or pressure at the bridge of the nose. Hyoscyamus is highly recommended by Dr. Charles E. Teets, of New York, as one of the best remedies for the treatment of atrophic rhinitis.

Hay Fever.—I cannot pass this topic without saying one word about the fact that naphthalin is constantly adding to its laurels in the cure of pollen catarrh, and that gelsemium is gaining its proper place among the prophylactic remedies useful in combating this neurosis (?). It is pleasing to know that the wholesale destruction of sensitive areas is giving place to the more conservative method of reducing the actual obstructions of nasal respiration.

Nasal Neuroses.—Of these, neuralgia of the face and head and reflex conditions are now receiving the attention that has so long been denied them. In many cases the reduction of hypertrophies or pressure-tissue due to engorgement, has resulted in a speedy and complete cure of some of the most obstinate neuralgias of this region. In numerous instances relief has been obtained by the insufflation of finely powdered chloride of sodium. In others it has been necessary to employ the galvano-cautery to reduce large, turgescient regions by making a slight incision into the engorged tissue.

Papillomata of the Nose.—One word will suffice with reference to these infrequent growths, which are always found directly within the vestibule upon the cartilaginous septum or lower turbinated body. Some writers have, within a short time, endeavored to prove that these neoplasms occur very frequently, but caution is necessary to discriminate between the true papillomatous growth and a roughened, hypertrophic condition of the membrane, frequently found in this region.

Local Anæsthetics.—While cocaine still holds a large share of confidence in this capacity, there are cases in which it is unsafe to use it; therefore, great efforts have been made to replace or augment its action by some drug which will not be injurious to the patient. Antipyrin, 1 to 3 per cent. solution, has proven most satisfactory, in that it is not only anæsthetic, but anti-spasmodic and, when used in the nose, diminishes reflex cough and asthma due to nasal defects;

above all, the drug is highly antiseptic. Its analgesic action lasts many hours, thus often making it more satisfactory than cocaine. There seems to be but one disadvantage, viz.: its application is more irritating than that of cocaine.

Trans-illumination.—This important adjunct to the diagnosis of the diseases of the antra and ethmoidal sinuses, has gone far to alleviate a class of maladies which has often rendered the surgeon inoperative in relieving obscure symptoms of this region. While trans-illumination does not clear up each case, it must be admitted that it has done much for this branch of rhinology; and Garel calls attention to a new sign,—absence of luminous perception on one side by the patient himself. With a lamp in the mouth of a healthy subject, whose eyes are closed, a luminous impression is produced upon the lower part of the retina. In four cases of unilateral empyema of the antrum, Garel observed that this luminous perception was suppressed on the side containing pus.—*Annales des Maladies du Larynx*, etc., February, 1893.

Fibroid Tumors of the Naso-Pharynx.—It is more than pleasing to note the yearly change which has taken place in the treatment of these growths of the naso-pharynx. The more conservative methods of electrolysis and the galvano-cautery puncture have almost superseded the less rational capital operations, such as those of Rougé and others, from which loss of life has been noted. Few cases now fail to respond to the more rational measures, thus giving a far better prognosis than was formerly possible. The cautery loop has long been used, but occasional fatal results follow.

Physiology of the Tonsils.—Hodenpyl "Alumni Prize Essay," College of Physicians and Surgeons, New York, May, 1890, formulates the following conclusions:

1. The tonsils are lymphoid structures closely resembling the Peyer's patches of the small intestine, consisting in general of a congeries of lymph nodules separated from one another by diffuse lymphoid tissue which is arranged about several of the hollow depressions of the epithelial lining of the glands.

2. None of the theories thus far advanced to explain the functions of the tonsils are conclusive.

3. The tonsils produce no physiological secretion.

4. The tonsils are not absorbing organs. They neither absorb fluid nor solid particles from the mouth under ordinary conditions, nor do they take up foreign materials from the tissues in their immediate neighborhood.

5. Tubercular tonsillitis is an uncommon affection.

6. There is no evidence to show that pulmonary tuberculosis ever results from absorption of tubercle bacilli from the mouth through the tonsils.

7. Rarefaction of the epithelium of the tonsils offers a ready explanation of the way in which the contagium of diphtheria may gain entrance to the general circulation in this disease.

This valuable thesis, therefore, sets aside many of the theories which have been prevalent for years, doing away with a source of supposed contamination, and places once more upon the broad field of doubt the function of these organs, the diseases of which give rise to such discomfort to the patient and often result in serious consequences to the general health.

Tonsillitis.—Of late this subject has given rise to considerable discussion, and has even formed the title of a large monograph by Allard ("Les Amygdalites Aigues"), who believes that the causes of this disorder are micro-biological and that the hypotheses which regard tonsillitis as a general infectious disorder, the fever of which the angina is only a manifestation, are the more rational and the most in keeping with the majority of the facts. It is now almost generally admitted that tonsillitis is often infectious, with resultant nephritis, orchitis, endocarditis and arthritis. Cases of papular erythema and purpura complicating tonsillitis have been reported recently. In some cases even a trace of albumin has been discovered in the urine, but as this is a condition which might possibly be complicated by other and antecedent disorders, it can scarcely be looked upon as an actual complication or sequel of amygdalitis. In the last few years much attention has been drawn to the resemblance between follicular tonsillitis and diphtheria, many authors, in fact, failing to find a differential diagnosis, some even claiming that the usually milder affection is but a forerunner or even a modified form of the latter.

Hypertrophied Tonsils.—In passing I wish to suggest one remedy for enlargement of the tonsils, which has not been so far spoken of by others and which has proved, clinically, the most useful remedy tried, namely, *ignatia* 30x, with nodulated, slightly inflamed tonsils. especially in nervous persons, when the right tonsil is the worst, and with associated enlargement of the right anterior cervical glands.

Cancer of the Tonsils and Pharynx.—Although arsenic, *hydrastis* can. and *phytolacca* still hold high positions as therapeutic measures in the treatment of this fatal affliction, the recent employment of

calendula in a 20 per cent. solution, together with its internal administration in the 2x or 3x has given a decided impulse to the internal administration of drugs in pharyngeal cancer, and Dr. H. C. French (*Pacific Coast Jour. Hom.*, January, 1893) writes very flatteringly of the action of "a paste of red clover (*trifolium Americano*) applied to an ulcer (epithelioma of the eyelid), and the same remedy taken internally in doses of from two to five drops of the fluid administered three times daily has, in the hands of the writer, proven both prophylactic and curative. The strength of the paste must be graded to the susceptibility of the patient by the addition of slippery elm powder. Under this treatment we have seen an ichorous discharge become bland or cease entirely, the rough edges become smooth and the hard base softened." We welcome this new remedy for such a serious malady and will place it alongside of the preceding drugs.

Guaiacum.—Dr. Wm. C. Goodno, of Philadelphia, says that "in the ordinary form of pharyngitis, such as is so frequently developed after cold, it is nearly a specific remedy, much superior to belladonna and other remedies which are generally administered." Acting upon this suggestion contained in *THE HAHNEMANNIAN MONTHLY*, February, 1891, I have used the remedy very extensively in both acute and subacute pharyngitis, and am heartily in accord with the doctor. The indications upon which I prescribe are partly empirical, but often recently certain appearances guide me in its administration, namely: the congestion, which is less bright than the belladonna and is on either side of the throat; the pharynx at times is slightly glazed, at others infiltrated; much follicular involvement, and the patient complains of a smarting, especially burning, likening it to the effects of pepper. When given early and repeatedly, using the 2x or 3x, it acts promptly, and in a large number of cases has cut short acute pharyngitis in patients who are accustomed to have long sieges from similar beginnings.

Diphtheria.—Some authors have disclaimed any marked contagiousness of diphtheria unless the bacilli be of unusual virulence, a few writers even claiming absolute non-contagiousness of this malady. This seems like very bad teaching, especially should the laity be apt scholars. Dr. Bourges (*La Diphtherie*) studies the subject from the following standpoint: Diphtheria is a contagious disease due to the bacillus described by Klebs and later studied by Loeffler. He claims that the diagnosis between the false diphtheria of scarlatina and true diphtheria is always difficult, and often even

impossible. In order to prevent the spread of diphtheria when there is a vesicular eruption (containing the diphtheria bacilli) on the udder of newly-calved milch cows, the milk should be boiled, thus not materially interfering with its nutritive value. Such an origin of this dread disease renders it important that extreme measures be instituted to prevent its spread by appointing dairy inspectors. When the condition is discovered, the sale of the milk should be prohibited, the udders thoroughly disinfected, and the wet, unsanitary condition of the cow-sheds speedily remedied. In the local treatment of diphtheria there seems to be a growing tendency to discard the harsher measures, substituting those which are less objectionable to the patient, and which can be applied without giving rise to so much resistance. Of the internal remedies, perhaps none has recently created so much discussion as permanganate of potassium, introduced by Dr. I. W. Heysinger, of Philadelphia, about fifteen years ago, but which had practically been neglected until Dr. Heysinger's paper upon the subject appeared in the *Jour. of Oph., Otol., and Lar.*, January, 1892. The doctor looks upon the remedy, when given in the earlier stages, as an infallible specific. He uses about one grain of the crystals in three ounces of pure water, giving one teaspoonful, together with mother tincture of bell., every hour or so. He further employs the permanganate as a prophylactic. Acting upon his suggestions, a number of physicians have used it with very gratifying results.

Benign Ulceration of the Pharynx.—Besides establishing the identity of this condition, first described by Heryng, Masucci (*Revue de Laryngologie d'Otologie et de Rhinologie*, October 15, 1891) has proved the existence of special bacteria, the streptococcus monophormus and variegatus, described by Heryng and Ludwig, demonstrating the benignity of the affection. The lesion is usually unilateral and single, oblong in shape, and apt to appear upon the soft palate. The ulcer is covered with a grayish membrane, which disappears in a few hours, leaving no trace. This form of ulceration has been too slightly dealt with by writers in general, and most practitioners look upon it as of a syphilitic or phthisical origin. It is, therefore, well to call especial attention to this transient, benign, and simple ulceration, that patients may not be relegated to either of the classes above named.

Pyriiform Sinuses and the New Tonsil.—Dobrowolski, of Warsaw (*Jour. of Lar., Rhi., and Otol.*), has presented a very important thesis bearing upon this subject, in which he states that in general

the papillæ and mucous glands are not numerous in the sinuses. As to the follicles, the author regards the pyriform sinus in his cases (sixty) under four categories. In the first and the most numerous (almost one-half) cases, there were no folliculi, only a circumscribed infiltration under the epithelium. In the second (less numerous), the adenoid tissue under the epithelium contained nodular agglomerations, similar to the tonsils. In the third class, the adenoid tissue was in the form of single sacciform glands, identical with those of the base of the tongue. Finally, in the last class (eight cases), these glands were agglomerated in the shape of the tonsils, thus leading him to the classification of a new (pyriform) tonsil, or, as named by Dobrowolski, "tonsilla laryngea saccus—sinus pyriform saccus—5th tonsil." This latter was present in six cases on both sides (generally at the bottom of the pyriform sinus), and was more or less of the size of a bean. The tonsil was composed of from four to fifteen sacciform glands. That author regards the laryngeal tonsil as a normal, though not constant, organ, similar to the lingual, pharyngeal, and faucial tonsils.

The Epiglottis.—Recently, the theory that the epiglottis descended in such a way as to cover the upper portion of the larynx during deglutition, has met with a temporary rebuff in the new theory that it remains upright during the act of swallowing, closure of the sphincter serving to prevent the entrance of food. According to Michelson, this cartilage has a taste function on its posterior face, which, although long known, was not proven experimentally until quite recently.

Functional Aphonia.—The chief advancement of recent years with reference to the treatment of this neurosis consists in the cure by hypnotic suggestion. This measure has been found very efficacious in numerous instances in which other and approved measures had been used in vain.

Contraction of the Transverse Arytenoid Muscle and Bilateral Paralysis of the Posterior Crico-Arytenoid Muscles.—Ruault and others have endeavored to clear up many cases of diagnosis of posterior crico-arytenoid paralysis by substituting that of contraction of the transverse arytenoid muscle. These two conditions are claimed, by various writers, to be one and the same, and Krishaber looked upon them as a unilateral spasm of the arytenoid muscle. Mackenzie, Seymour, and others admit, besides paralysis of the abductors, secondary contraction of the adductors; but there is a growing tendency to look upon the condition, in many cases, as "a primary contraction

of the adductors with, in certain cases, a secondary myopathic paralysis of the abductors and atrophy of these muscles consecutive to their functional inertia."—*Jour. of Lar., Rhin., and Otol.*, August, 1892. Ruault (*Maladies du Nez et du Larynx*), in discussing abductor paralysis and adductor spasm, arrives at the conclusion that it is most probable that irritation of one recurrent nerve, such as is produced by slight compression, induces spasm, convulsions, or intermittent tonic contraction of the band, lasting for a short time, rarely more than a week; that these actions may disappear with their cause and recur and disappear, but if the pressure continue, it very rapidly determines a paralysis, limited at first to the dilator muscle; and if the pressure be from the first sufficiently severe, it determines sudden paralysis, either limited at first to the dilator or immediately generalized.

Laryngeal Phthisis.—While cocaine was far in advance of the older application, morphia, in relieving pain and enabling the patient to swallow comfortably where this act was exceedingly painful, the drug which will to a great extent supersede both of the preceding, at the same time proving more or less curative, is the local use of calendula as advised by Dr. A. C. Peterson, of San Francisco. He sprays into the larynx a watery solution of 1 to 20, or weaker, with the addition of two or three drops of carbolic acid to the ounce, but I have had better results from a petroleum solution, calendulaol, as manufactured by Clapp and by Buffington.

Cysts of the Larynx.—Until very recently, cystic tumors of this organ were looked upon as exceedingly rare, but of late many cases have been reported. The causes of these cystic formations are various, viz.: retention (Kantack), atrophy, excitation, and hæmorrhages. Schrötter believes that they are of the same origin as milium vesicles; many cases originate from neoplastic growths. It has long been taught that cystic tumors of the larynx, when once ruptured, rarely refilled, but it is now well known that the contents may reaccumulate many times before complete destruction, thus leading to the treatment by cauterization or by evulsion of a large portion of the sac.

Intubation.—Although O'Dwyer's original idea seems to have been to use intubation for the purpose of relieving acute laryngeal stenosis, especially if caused by membranous deposits, the method has been carried much further. It is valuable not only to such cases, where it has a reputation equal to that of tracheotomy, to which it is vastly superior in many forms of chronic stenosis, especially when of

a syphilitic character or when complicated by the presence of benign growths. One of the objections to intubation has been a difficulty in introducing the tube, owing to its entrance into one of the ventricles of the larynx, thus preventing its passage through the glottis. To the inexperienced this has sometimes proved an insurmountable obstacle, but it can usually be overcome by rotation of the introducing handle from right to left, or *vice versa*, and the tilting of the tip of the instrument toward the opposite side of the larynx. O'Dwyer, in *The Annual of the Universal Medical Sciences* for 1892 (to which publication I am indebted for many valuable suggestions in the preparation of this review), says: "While I have often had the progress of the tube arrested by entering one of the ventricles, I never found any great difficulty in disengaging it by rotating the introducer or otherwise changing the direction, until a few months ago, when I was called to the New York Foundling Asylum to intubate an infant five months old, in which the resident physician had failed after many trials. After four careful and prolonged attempts I was about to give it up as useless, when it occurred to me that if the long diameter of the tube could be brought across the long diameter of the chink, either transversely or obliquely, the increased size in this direction would prevent it from engaging in the ventricle. This was accomplished by swinging the handle of the introducer well around in the left angle of the mouth, when the tube slipped in without difficulty. This impediment to intubation results from the entering portion of the tube being too small instead of too large, and the remedy consists in increasing the size of the distal extremity by making it cylindrical instead of oval, as at present constructed." This manoeuvre I have sometimes found necessary in intubating, and I believe that O'Dwyer's notice of it will not only render the operation easier, but go far toward making possible the introduction of the tube in all cases. One word of warning is here necessary; if much force be exerted when the tube is in the ventricle, perforation will occur, and the tube be forced down between the cartilaginous and soft structures, not only thwarting the object of the intubation, but occasioning a greater amount of dyspnoea, even after the tube has been withdrawn. Maydl, of Vienna, has employed intubation as a means of obviating the entrance of fluid into the respiratory organs during operations. The tube is connected with a drain, to which is attached a funnel. The pharynx is then tamponed with iodoform gauze. Through the funnel the patient respire and can be narcotized. He says that in this manner it is possible, in operations upon the mouth and pharynx, to prevent aspiration of blood and wound

secretions, and even glottic spasm, without performing tracheotomy. The doctor has tried his method in several cases with good results, and it was further found that the apparatus could remain in the trachea at least twenty-four hours without harm.

Phonetic Roll of the Trachea.—The causes of the great variety in the pitch of various voices, especially in singing, has been the occasion of many theories, some basing the difference upon the length of the trachea or the vocal bands, and the various resonant cavities of the throat, nose, and head, including the accessory sinuses. Dr. Moura, of Paris (*Jour. Lar., Rhin., and Otol.*, April, 1893), who has made a series of experiments, claims that much depends upon the relative length of the trachea and vocal bands and the relative diameter of the cricoid cartilage and trachea, together with the constant change which the latter undergoes during vocalization, in that its diameter is altered according to the pitch of the tone. "The parallelism of anatomical development between the length of the ligamentary glottis and the diameter of the trachea, and the diameter of the cricoid is very often defective;" thus, in two similar subjects, whose vocal ligaments measured 9 mm., the diameter of the trachea was in one 8 mm., and in the other 14 mm. The voice of the first cannot have the same tone as the latter. In one the voice must be heightened, and in the other lowered. The inverse of this is seen in the vocal ligament of 2, 3, and 4 mm. longer than the calibre of the trachea; the influence of the tracheal wave is to raise the glottic tone.

Foreign Bodies in the Œsophagus.—B. Poliker, of Warsaw (*Revue Mensuelle des Maladies de l'Enfance*, January, 1891), gives a very simple method for the extraction of some foreign bodies from the œsophagus. In two cases where the body could not be discovered, either by laryngoscopy or by the ordinary methods, by placing one finger in the space between the trachea and sternocleido mastoid muscle on the right side, and pushing upward he was able to find a little elevation below the cricoid cartilage. While with one hand he tickled the child's throat, he made an effort of massage with the other, by pushing the body upward and backward; when in a few seconds, the child, in each instance, vomited a coin. The conclusions which may be drawn are that, notwithstanding the deep position of the œsophagus, it is often possible to find a foreign body by external manipulation, thus making this simple method worthy of trial, rather than as is usually done, force the body downward into the stomach where it may occasion annoyance, or even do considerable harm.

EDITORIAL.

THE HOMŒOPATHIC MEDICAL SOCIETY OF PENNSYLVANIA.

THE next annual meeting of the Homœopathic Medical Society of the State of Pennsylvania will be held at the Pittsburgh Homœopathic Hospital on September 19th, 20th, and 21st, 1893. The Pittsburgh physicians, always active in the best interests of the State Society, have long been at work perfecting every detail necessary to assure an absolute success for the coming session. The date has been fixed so as to afford an opportunity to the members of the profession who were not able to reach Chicago last June to do the "White City" by the lake thoroughly, and return in ample time for the first day's session, Tuesday, September 19, 1893. There should be an unusually large gathering at Pittsburgh this year, and an especially large accession of new members. Every member of the homœopathic profession in Pennsylvania should be enrolled. The State of Pennsylvania, in the Medical Examiners' Bill, has recognized the Homœopathic Medical Society as the répresentative organization of the State, and a physician to be eligible for appointment on the Homœopathic Medical Examiners' Board must be a member of the State Society. Interests of vast importance to homœopathy demand the most careful consideration and action of the school preparatory to the next meeting of the State Legislature. The habit of deferring the considering of weighty legislative matters until just before the meeting of the Legislature is erroneous and weakening. Plans should be formulated now and be persistently worked out during the entire year. In this way the Committee on Legislation could draft and present at the 1894 meeting a comprehensive report suggestive of the proper line of action to be pursued. A carefully considered report of this character would be of true value to the Society, and would invite and rightfully claim the sympathy and enthusiastic support of every member. The organization of the profession in the State, as it now stands, is absolutely worthless for effective work, it being impossible to secure the co-operation of the majority of our physicians. We have not even a reliable directory.

It is a duty of the State Society to encourage and foster local societies in every county of the State, and have them report regu-

larly. Each year a correct and revised roll of all physicians practicing homœopathy should be printed in the *Transactions*, some method being adopted to distinguish non-members. Such a roll would assist greatly in bringing new members into the fold, and it would be of constant use to the members of the Society, especially to the Legislative Committee. President Joseph C. Guernsey, M.D., is wide awake to the needs of the Society, and an especial effort will be made to take an unusually large delegation from Philadelphia to the Smoky City.

FREE DISPENSARY ABUSE.

WE have frequently dwelt upon the dispensary abuse and the injury it was working to the physicians themselves, especially those in the bread-winning portion of their career; to the pauperizing tendency of those who largely attend the "out" clinic department who are really able to pay for service; and to the injustice done the worthy poor by the overcrowded condition of all large dispensaries, taking the time of the physicians they rightly have a claim to. In the *HAHNEMANNIAN MONTHLY* for February, 1893, Theodore L. Chase, E-q., in an able article called attention to the glaring abuse of this class of charities situated in Philadelphia and New York, and the following quotation from an article entitled "Private Relief of the Poor," by Herbert Spencer, in the *Popular Science Monthly*, for July, 1893, shows the deplorable condition of affairs in the city of London:

. . . . Now it is otherwise with institutions thought by most people to be indisputably beneficial,—hospitals and dispensaries. The first significant fact is, that 30 per cent. of the people of London are frequenters of them, and the largeness of this proportion makes it clear that most of them, not to be ranked as indigent, are able to pay their doctors. *Gratis* medical relief tends to pauperize in more definite ways. The out-patients begin by getting physic and presently get food, and the system leads them afterward openly to solicit pecuniary aid. This vitiating effect is proved by the fact that during the forty years from 1830 to 1869 the increase in the number of hospital patients has been five times greater than the increase of population, and as there has not been more disease, the implication is obvious. Moreover, the promise of advice for nothing attracts the mean-spirited to the extent that the poor are now being gradually

ousted out of the consulting-room by well-to-do persons. People of several hundreds a year, even up to a thousand, apply as out-patients, going in disguise, 20 per cent. of the out-patients in one large hospital having given false evidence for the purpose of concealing their identity. Swarming as patients thus do, it results that each gets but little attention, a minute being the average for each, sometimes diminished to forty-five seconds. Thus, those for whom *gratis* advice is intended get but little. Often the assistance given is merely nominal, and is both a deception on the public and a fraud on the poor. These gratuitous medical benefits, such as they are, are conferred chiefly by members of the unpaid professional staffs of these charities. Some of them prescribe at the rate of three hundred and eighteen patients in three hours and twenty minutes,—a process sufficiently exhausting for men already hard worked in their private practice, and sufficiently disheartening to men with little private practice, who thus give without payment aid which otherwise they would get payment for, very much needed by them.

So that the six hundred thousand pounds a year of the metropolitan hospitals, which, if the annual value of the lands and buildings occupied were added, would reach very nearly a million, has largely the effect of demoralizing the patients, taking medical care from those it was intended for and giving it to those for whom it was not, and obliging many impecunious doctors and surgeons to work hard for nothing.

These various experiences then furnished by societies and institutions supported by voluntary gifts and subscriptions, unite to show that whatever benefits flow from them are accompanied by grave evils—evils sometimes greater than the benefits. In proportion as beneficence operates indirectly instead of directly, it fails in its end.

ERRATA.

IN July number, paper, "Supplementary Remarks Upon Some Medicines Little Used, etc.," by W. C. Goodno, M.D., wherever the word *colchicum* appears read *colchicine*. Line 13, p. 455, "℥v" should read "℥j." Page 457, fifth line from bottom, "codeina" should read "codeia." Page 460, line 22, "℥s" should read "℥j" and fourth line from bottom "ben" should read "bell."

IN June number, paper, "Acute Melancholia," by Charles B. Gilbert, M.D., page 375, ninth line, for "aes." read "aconite." This case was treated in 1888.

GLEANINGS.

GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D., AND FRANK H. PRITCHARD, M.D.

DIABETES.—Dr. Harley makes the following divisions: 1. Hepatic diabetes, including the gouty variety. 2. Cerebral diabetes, including all cases of saccharine urine arising from nerve derangement. 3. Pancreatic diabetes, the most deadly form of the disease. 4. Hereditary diabetes, a form by no means uncommon. 5. Food diabetes, arising from ingestion of unwholesome substances.

The presence of sugar in urine is due to a disordered animal chemistry, diabetes being, like gout, a chemical form of disease. This faulty chemistry leads to a clinical division into two great classes, diabetes from excessive sugar formation; diabetes from diminished saccharine consumption, malassimilation. Patients belonging to the first class are, in general, well nourished, and amenable to treatment. Those of the second class are little influenced by medicine or diet, and the vast majority succumb to the exhausting effects of the disease within a few months after its commencement. As an example of these two classes, the hepatic form represents that arising from excessive sugar formation; and pancreatic diabetes, that resulting from malassimilation.

The prognosis is governed mainly by some of the following signs and symptoms: If there is no loss of flesh taking place, the patient, with proper care and attention, may live for years. When the loss of flesh is very gradual, the patient may live a year or two; but when rapid, the chances of life are estimated by months only. The next sign of importance is the presence of acetone in the urine, the patient usually dies in six months (test per chloride of iron). A still more unfavorable sign is the advent of an ethereal apple-like odor to the breath. When this sets in, the prospects of life are reduced to weeks. A further warning of the approaching end we have in the presence of abberation of intellect and drowsiness, which are evidences of the toxic action on the nervous system of retained excrementitious matters. Finally, in addition to the nervous phenomena, the breathing becomes embarrassed, coma rapidly follows, and death.

As to treatment, endeavor to raise the general health of the patient to the highest standard possible, by giving him plenty of fresh air and healthy muscular exercise. In all cases of diabetes, the result of excessive sugar formation, as all hepatic cases are, a restricted diet is essential. The patient should avoid eating all wheaten, barley, oatmeal, or other forms of ordinary bread; pastry, pie-crusts, dumplings, pancakes, porridge, as well as all kinds of farinaceous puddings, sago, rice, corn-flour, arrowroot, revalenta, malts and maltine in any shape; liver in any form. Asparagus, potatoes, peas, beans, lentils, beetroots, parsnips, carrots and turnips, rhubarb, stewed or in tarts, chestnuts, raisins, prunes, and dried figs. In moderation he may eat oysters, clams, mussels, radishes, cucumbers, green French beans, melons, apples, peas, peaches, apricots, grapes, gooseberries, strawberries, and cherries; almonds, filberts, walnuts and hazelnuts. He may eat butcher's meat, game poultry, eggs, butter, cream, fish of all kinds, animal soups of all kinds, beef essences and extracts. Among vegetables he may eat cauliflower, cabbage, spinach, turnip tops, tomatoes, raw and cooked, onions and mushrooms, lettuce, celery, water-cress and sorrel. Puddings, egg custards, calves' foot, gelatine, blancmanges, sweetened with saccharin. Milk, cream, butter, and cod liver oil should be given freely. —*British Medical Journal*, May 27, 1893.

NATURE AND ORIGIN OF RENAL CASTS —This subject has been studied recently by Lubarsch. Certain authors have concluded that the homogeneous hyaline variety are composed of fibrin, because they can be stained by Weigert's fibrin-staining method, and have, consequently, taught that hyaline casts are formed out of

exuded albuminous constituents of the blood. Lubarsch shows that a number of hyaline substances found in the human body, having nothing to do with the fibrin, stained after the method referred to; further, that hyaline casts are brought out by dyes which do not stain fibrin. He concluded, after a series of observations, that these casts originate, not in an exudate, but in a secretion from, or in actual disintegration of the renal cells.—*Ibid.*

APICAL PULMONARY TUBERCULOSIS IN AN INFANT.—Herbert Wild, M.B., reports a rare case of apical pulmonary tuberculosis in an infant of nine months. The diagnosis was established and confirmed by the detection of tubercle bacilli in the sputum, and by a post-mortem examination. The family history was phthisical; mother a consumptive at birth of child, and maternal grandfather died of phthisis. Child was healthy at birth, remaining so for first few weeks. Mother's milk failing, child was weaned. Notwithstanding careful dietary, malnutrition became manifested, followed by an unyielding diarrhœa. At end of fifth month the existence of tuberculosis was clearly established, the condition being one of marked asthenia and emaciation. Under the administration of *Iodum* a surprising improvement took place; in one month the child, while thin, appeared well. Beginning of seventh month a second change occurred; cough commenced, followed by profuse night-sweats, weakness, and emaciation. Physical examination showed a diffused bronchial catarrh; later, a localized percussion dulness was detected at the left apex, with bronchial breathing more or less concealed by coarse, bubbling râles. Later, the right apex presented the same condition modified. Diarrhœa again started up, associated with vomiting. The ejecta contained purulent nummular material, which microscopically showed numerous pus-cells with a few tubercle bacilli. Infant died at ninth month. Post-mortem showed left apex densely studded with small yellow tubercles; Towards base tubercles were few and smaller; right lung similar but less marked; Bronchial glands greatly enlarged, hard, and caseous.

On section, left apex showed beginning softening; adjacent bronchi were choked with thick puriform material similar to the vomited matter during life. It showed developed bacilli among masses of pus cells. The mesentery glands were found to be more or less enlarged and partially caseous. The intestines presented a fairly healthy appearance. The writer considers that a doubt exists in this case as to the origin of the pulmonary tuberculosis,—whether arising from a secondary extension of the abdominal lesion, through the medium of the bronchial glands, or through direct maternal infection after birth,—the former hypothesis being improbable, from the fact that the lungs were principally and primarily affected at the apices, and that secondary extension would occur subsequent to the apparent arrest of the primary process. Maternal infection of the infant was probable, she, at the time, expectorating freely a muco-purulent sputum containing numerous tubercle bacilli. Cornet having shown conclusively the highly infective nature of tuberculous sputum when reduced to the condition of fine dust, special emphasis is laid upon the great probability of enteric infection from moist sputum conveyed by wiping an infant's mouth with a handkerchief containing tuberculous sputum.—*The Monthly Homœopathic Review*, July, 1893.

PHTHISIS—THE IMPORTANCE OF CAREFUL AUSCULTATION IN THE FIRST STAGES.—Dr. Percy Kidd, in the *Chemical Journal*, points out some sources of error required to be guarded against. There is no disease in which it is more important to recognize, without misconception, the early stages than phthisis. You should always keep, so to speak, one eye on the patient. "In this case on auscultation at the supra-spinous fossa, I hear some crepitant sounds after the patient coughs, but on requesting him to cough again without swallowing afterwards, the râles are no longer heard; that is to say, the râles were produced by the act of swallowing. This is a common error, which it is very necessary to guard against in auscultation of the apices of the lungs. Another point to notice is the patient's method of breathing. Some persons, unintentionally, make a loud noise in the pharynx when they breathe through the mouth. In such case the breath-sounds heard at the apex of the lung acquire a harsh, bronchial quality, which is apt to give a false impression. In all healthy chests, more particularly in those which are thinly covered, the expiratory sound at the apex of the lung is more prolonged than elsewhere, and may even be distinctly bronchial on the right side. Again, increased resonance of the voice, or broncophony, may be audible at the apex, especially on the right side, without any actual disease being present. This is due to the proximity of the large bronchi to the chest-wall in the apical region. The increased loudness of the vocal resonance

The first case of the disease was reported by Dr. J. H. ... in 1891. It was a case of ... which was ...

The second case was reported by Dr. ... in 1892. It was a case of ... which was ...

The third case was reported by Dr. ... in 1893. It was a case of ... which was ...

The fourth case was reported by Dr. ... in 1894. It was a case of ... which was ...

KYPHOSIS BICYCLISTARUM.—One evil traceable to bicycling is the confirmed stoop which has already declared itself in many wheelmen, a result so common in the less strongly built bicyclists of the Continent as to have found its way into classification as the "kyphosis bicyclistarum." The dorsal curvature posteriorly—kyphosis proper—which used to be rare in boys under fourteen years of age, is now that the bicycle is so largely used before puberty, very frequently met with, particularly among those young bicyclists whose spinal column is developing more rapidly than the ligaments and muscles. Were it only an unsightly deformity, the "stoop" in question ought to be combated in every way; but the confirmed dorsal curvature posteriorly has sequelae of its own quite mischievous enough to call for immediate counteraction. The displacement, embarrassed functional activity, and arrested or diseased development of the thoracic viscera, which kyphosis inevitably induces, are all too serious to be neglected. Exercise of a kind to accustom the spinal column to an action directly antagonistic to the "inclination forward" of the bicyclist's attitude is what is manifestly indicated, and the use of Indian clubs, or such similar means of throwing out the chest and maintaining the head

erect, should be practiced with that object. All the undoubted advantages of bicycling might thus be retained without that cultivation of the "stoop" which tends to take a "cubit from the stature," and to impose a hunchbacked development on what would then figuratively be called a "rising generation."—*Ibid.*

THE INSOMNIA OF NEURASTHENIA.—Dr. Hedley reports the case of a physician in active practice, who suddenly broke down from overwork, his greatest trouble being insomnia. He had tried all sorts of devices which are recommended for sleeplessness, such as counting, following the tick of a clock, etc. A multitude of drugs had been tried, all of which failed except sulphonal, which gave him sleep, but produced evil effects of its own. His condition grew gradually worse, until he became greatly prostrated, hypochondriacal, and pretty thoroughly wrecked. At this juncture electrization was begun. On account of hypersensitiveness, the weakest possible current had to be used at first, and even that caused him to shrink. Gradually the current was increased until he was induced to try a bath through which a mild current of a few milliampères was allowed to pass. From that time he began to sleep better, and continued to improve through the seven weeks of treatment, at the end of which time he began to make arrangements to resume his practice.—*Ibid.*

BRONCHO-PNEUMONIA IN CHILDREN.—M. J. Simon, *Gazette des Hôpitaux*, No. 25. The broncho-pneumonias in children have a progress and character essentially variable. Three principal forms are recognized: the violent, the acute, and the common forms. The *violent* form usually results fatally in two or three days. Sometimes in a few hours. There is a generalized suffocating catarrh of the whole bronchial tree, producing speedy asphyxia. The chief symptoms are intense dyspnoea and distress, exaggerated percussion resonance over the whole thorax. Apnoea, fine râles generally disseminated. *Acute* broncho-pneumonia is also extremely severe. It rarely lasts more than a week. Here, in addition to the signs of capillary bronchitis, evidence of the presence of pneumonia nodules can be discovered by percussion. The functional symptoms are of more importance than the stethoscopic signs. The onset of the *common* form of broncho-pneumonia is insidious. In the course of whooping cough, grippe, laryngitis, or even of simple coryza in a child who has been exposed to cold, languor, fever, cough, and respiratory distress appear. The fever rises slowly, taking two or three days to exceed 102° F. Physical signs negative. Later areas of hyper-resonance, of airlessness, and fine râles manifest themselves. The essential character of the disease is the progress by oscillations and exacerbations. From time to time periods of amelioration, and even apparent cure, supervene. Then fresh nodules are formed. Fever recurs. These oscillations produce a medley of stethoscopic symptoms, the locality of the signs alter day by day, even changing from one side of the chest to the other. The alternations of improvement and relapse may continue for a month. Often the children succumb, dying suddenly from syncope, or rapidly from asphyxia, or more slowly by progressive exhaustion. In recovery, convalescence is slow. For at least a month after complete deservescence we have still to deal with a patient rather than a convalescent. It may take a year or more for the last traces of emphysema and atelectasis to disappear. A diagnostic error at this period of decline of the broncho-pneumonia of common occurrence arises from the fact that when the nodules disappear the consequent dilatation of small bronchi gives stethoscopic signs which simulate the signs of softened tuberculous nodules which have arrived at the stage of small cavities. The child is pale, emaciated and greatly exhausted, suggesting strongly tuberculosis, often misleading one when recovery is near into giving a serious prognosis. As long as the lesions do not affect the apices of the lungs predominantly and constantly, the diagnosis of tuberculosis is doubtful. It is more probably a simple bronchial dilatation, requiring great care, but perfectly curable.

For the development of broncho-pneumonia the conjunction of two factors is required, viz., an infective agent and a soil prepared for the development of this agent. The infective agent may be the streptococcus, the pneumococcus, or the staphylococcus, the first predominating in lobular, the second in pseudo-lobar pneumonias. These microbes are never found in the normal lung, but exist in health in the mouth, throat and nose. A penetration into the air passage is easy when favored by a congenial soil. This exterior origin is shown by the predominant localization of these microbes. They are more numerous in the bronchi than in the alveoli, and in the alveoli they are more numerous in the centre than at the periphery. In

order that this penetration may be accomplished the soil must be prepared. Broncho-pneumonia is the disease of children debilitated by diphtheria, measles, whooping-cough and grippe. It may even follow simple pharyngitis, coryza, or a slight cold. Often, then, a chill intervenes as the causal agent. It occurs most commonly in children from two to four years old, the age when supervision is most difficult, the vital resistance being still feeble.—*The Medical Chronicle*, July, 1893.

BATHING AFTER EXCESSIVE EXERCISE.—The popular notion of the injurious effect of a cold bath taken by one who is over-heated from exercise must possess—as all such ideas have—some basis in experience; and yet it is falsified by the experience of athletes from the days of the Greeks and Romans even until now, who find in this procedure a refreshing and stimulating tonic after the exertion they have recently undergone. And, physiologically speaking, a cold plunge or douche taken immediately after the physical effort, when the skin is acting freely and there is a sense of heat throughout the body, is as rational as in the experience of the athlete it is beneficial. It is paralleled by the tonic effect produced by the cold plunge when the skin is actively secreting after a Turkish bath, and finds its rationale doubtless in the stimulation of the nervous system, in the increase of internal circulation, and also in the renewal of activity to the cutaneous circulation after the momentary contraction of bloodvessels due to the cold. The popular belief doubtless rests on the injurious effects which may be induced by the bath in one who does not resort to it immediately, but allows time for the effects of fatigue to show themselves on the muscles and nerves and for the surface of the body to get cool. Taken then the bath is more likely to depress than to stimulate, there is less power of reaction and greater liability to internal inflammations. At such a time a warm bath rather than a cold one is more suitable and more safe. It has been suggested, however, that the practice of indulging in a bath after violent exercise may initiate renal disease. Of this there is no evidence. The transitory albuminuria observed after prolonged cold baths may indicate the disturbances in the renal circulation which ensues upon them, but these cases are in a different category from those to which we are now alluding, nor are we aware of any facts to prove that, even in them, Bright's disease has been developed in consequence of the transient departure from the normal. Lastly, it must be remembered that those indulging in athletic exercises of all kinds are presumably sound in heart as well as limb, and that such persons may take with impunity, and, indeed, with benefit, measures which would be distinctly harmful to the weakly.—*The Lancet*, July 8, 1893.

AMYL NITRITE IN ANGINA PECTORIS.—Dr. D. J. Leech in the Croonian Lectures on the pharmacological action and therapeutic uses of the nitrites and allied compounds, says: The inhalation of amyl nitrite sometimes fails to relieve the pain of angina pectoris; this failure may arise from several causes: (1) The paroxysm may be due to neuralgia of local origin, or it may be reflected or hysterical and circulatory changes may take but little part in its production. In such conditions nitrate inhalations can do no harm, yet they may fail to relieve pain. (2) In some cases the nitrite does not remove pain because of the short duration of its action. It does not break the spell of the vessel contraction. There may be relief, but it is not complete, and when in a minute or two the effect of the drug passes off, the wave of contraction returns, and with it the pain. (3) Some are curiously insusceptible to the influence of amyl nitrite. In such people full inhalations may succeed when slight ones fail, though this is not very common. If a certain measure of success is not obtained with ordinary inhalation, it is not often that a more copious use of amyl nitrite completely removes anginal pain. (4) Lastly, in very advanced cases where the attacks of pain continue long, amyl nitrite may entirely fail to relieve the pain, though in an earlier stage it proved useful for this purpose. If from any of these causes amyl nitrite does not remove pain, he advises one of the nitrites whose effects are more persistent. Of the official preparations, nitro glycerine (glonoin) is by far the best. It reduces tension more quickly than sodium nitrite, more quickly, too, than ethyl nitrite. Beginning with one drop of liquor trinitrini, the dose may be gradually increased until either the pain is relieved or unpleasant physiological effects as throbbing in the head or palpitation show that no more can be borne. In pain of hysterical or reflected origin this physiological limit is often quickly reached; in other cases very large doses may be given before relief is obtained. Dr. Murrell has given as much as 110 minims eight times daily as a remedy for angina pectoris. Some are very insusceptible to nitrites, especially

when passing through a dyspnoëic attack and it is worthy to note that the same individual may be more susceptible at one time than another.—*British Medical Journal*, July 15, 1893.

CAISSON DISEASE.—Henry E. Clark, in an article on "*Caisson Disease With Some Speculations As To Its Causation*," says the following physiological phenomena is experienced on first entering the compressed air chamber of a caisson. 1. Ringing in the ears and deafness, both passing off after a short time. 2. Respiration increases in frequency, and is short and gasping. 3. The pulse runs up to 120 or over, but afterwards falls to the normal rate. 4. The volume of the pulse is reduced; the superficial vessels, both veins and arteries, are diminished in calibre, and the surface of the body, therefore, presents a blanched appearance. 5. The temperature of the body is raised, and, after about an hour and a half in the chamber, is found to be maintained at about one degree above the normal. If the air in the chamber is itself raised, the body temperature goes up still higher, and has been known to reach 101° F. 6. The skin is covered with sweat, but it appears that this results from the air in the chamber becoming soon saturated with moisture, and that there is really diminished elimination by the skin. 7. There is increase of appetite. 8. The amount of urine is decidedly increased, and the composition and specific gravity are normal; this increase probably compensates for the diminished elimination by the skin. 9. The voice is altered, becoming more shrill, and the person speaks through the nose. Vevenot found that a lady singer gained a semi-tone when in the compressed air. It requires an effort to speak and whistling is almost impossible. These effects are experienced to a greater or less degree by all who enter a caisson. The pathological dangers produced by working in compressed air are: 1. Rupture of the membrana tympani; very few men who work in compressed air but have a considerable rupture of both drums. Many also suffer from otitis media purulenta, and are notably defective in their hearing. 2. Neuralgic pains are felt in the body and limbs, but more especially down the back. 3. There is often epigastric pain and vomiting, the matter vomited containing blood. 4. Paralysis, most commonly in the form of paraplegia, and involving both the motor and sensory nerves. In rare cases it involves the arms, and, in isolated examples, has also affected the face. 5. Cerebral congestion; headache, dizziness, double vision, incoherence of speech, unconsciousness. The essentials to safe working, briefly, are: 1. Healthy workmen, of spare habit of body, not alcoholic, and having sound hearts. 2. Slow decompression both in passing in and out of the chamber, and in passing material through the locks. 3. Men should not be constantly going in and out of the chamber. Two shifts of four hours each are quite as much as men can stand, and when in the workings they should stay the four hours. 4. The compressed air is very hot when it passes from the compressing cylinders; it should be cooled to about 70° F. There is no doubt that men working in the usual high temperature of the caissons, are liable to pulmonary troubles, and their risk of caisson disease is thereby much increased. 5. Newcomers should not stay in more than four hours a day for the first few days. Treatment: When accidents occur immediately on leaving the caisson, the best treatment is to put the man back in the air lock, and subject him to a modified pressure until he shows signs of recovery. Very little is said of treatment. Most of the fatal cases are so appallingly rapid that there is absolutely no hope of effecting anything by treatment. In others the unaided *vis medicatrix naturæ* is all sufficient. Ergot is recommended as likely to cause contraction of the vessels, thus diminishing the liability of hæmorrhages, and iodide of potassium as aiding absorption after hæmorrhages; both drugs are unreliable, however. Blisters and cupping over the spinal cord may cut short the inflammatory processes, but such agents are liable to cause sloughing if there is trophic disturbance. In paraplegia the Faradic current and massage are of use.—*Glasgow Medical Journal*, July, 1893.

ALLOPATHIC TREATMENT OF TRUE CHOLERA.—An anonymous writer in the *Provincial Medical Journal* for July, 1893, makes an open confession and says: The treatment of true cholera presents to us medicine in one of its feeble aspects. It shows to us the uncertainty under which we must act, for nearly every remedy in our pharmacopœia has been brought into service, has had a brief career, and has been displaced to make room for another. The following table exhibits this in a striking light. To check vomiting and purging: *Opiates*.—Opium, morphia, haschisch, chlorodyne, belladonna, morphia by subcutaneous injection. *Astringents*.—Acet. of plumbi, nitrate of silver, sulphate of copper, sulphuric acid, nitric

acid, catechu. *Curminatives* of all kinds. *Absorbents*.—Antacids, soda, magnesia, bismuth. *Sedatives*.—Hydrocyanic acid, chloroform, effervescing draughts, iced water, ice, external applications of ice, sinapisms, caustery to epigastrium, large doses of calomel or ipecac, creosote, naphtha. The writer states, we can have no exclusive treatment with our present knowledge of true cholera; we must be guided by symptoms in each case and the character of the epidemic. The great duty which devolves upon us relates to preventive treatment. The preventive measures to be adopted are as follows: The premonitory diarrhoea—should it be checked or encouraged? Check it. The Indian plan consists in the administration of a pill compounded of one gr. opium, two gr. asafoetida, or two gr. plumbi acet., one gr. opium, or ten gr. Dover's powder, or an equivalent of landanum or brandy or aromatic water or common chalk mixture. The patient is confined to bed, kept well warm on bland food; if there be tendency to colic warm cataplasms, and, if necessary turpentine stupes. The chief hygienic points given are two, cleanliness and the urgency of boiling all water during periods when cholera is in the air.

TREATMENT OF HABITUAL CONSTIPATION OF NEUROTIC ORIGIN.—Prof. Dubois, of Berne, read a very instructive and suggestive paper on "Nervous Disturbances of Appetite and Digestion," where he discusses *inter alia* the treatment of habitual constipation, which symptom is complained of by a vast majority of patients suffering from migraine, neuralgias, neurasthenia, hypochondriasis, hysteria, and such like neurotic conditions. Pretty frequently the constipation represents merely a product of such patient's fertile imagination. Thus, a short time ago Dr. Dubois came across a hypochondriacal elderly gentleman who had been daily clysterizing himself for the last score of years or thereabouts, being very firmly convinced that he was altogether impotent to get rid of his intestinal contents in a certain less artificial but more convenient manner. The author simply advised him to leave alone the enema apparatus, without prescribing any substitutes whatever. The result was most gratifying, the obstinate and inveterate "costiveness" disappearing as if by magic. Passing to the management of real nervous constipation, Dr. Dubois most emphatically recommends an exceedingly simple method, which has been as systematically as successfully practiced by him during the last decennium. No medicaments whatever are to be prescribed, but the following instructions should be given to the patient:

1. A regular rising from bed in the morning at a fixed hour (*e.g.*, 7 o'clock) in order to secure that stimulation of peristalsis induced by awakening should occur always precisely at the same time.

2. Taking a tumblerful of cold water (or a quassia infusion, if the patient, after all, insists to "have some medicine") immediately after getting up ("a second stimulation of peristalsis").

3. Taking breakfast (including Graham's bread and butter) always at the same fixed hour, *e.g.*, 7.30 A.M. ("a third stimulation of peristalsis").

4. Daily making an attempt at defecation at the same hour, *e.g.*, 8 A.M. ("a fourth stimulation of peristalsis").

5. Taking abundant amounts of food (especially of vegetables and fruits) at each meal.

Such ante-constipation code should be given to the patient not only *viva voce*, but on paper as well, and be accompanied by the practitioner's "absolute promise of success," *i.e.*, by an intense suggestion.—*The Provincial Medical Journal*, 1893.

BODILY POSITION IN THE DIAGNOSIS AND PROGNOSIS OF HEART TROUBLE.—Azoulay, a French writer, has recently issued a brochure upon the influence of posture on the heart-sounds. The idea is not absolutely new, yet, no "best posture" for examining the heart is, as yet, known. The author suggests, that what he calls the "raised position" presents fewer disadvantages than others, under certain circumstances. The indications thus obtained are more precise; and, in these, it is possible to discover any heart lesion when it does exist. Practically, the raised position is this: Place the dorsal decubitus absolutely on a horizontal plane, with a hard bolster under the neck to raise the head only; the arms are then crossed above the head, the knees are raised and kept together, and the heels are brought as close as possible to each hip-bone. This position must be taken without any abrupt movement, and without effort on the part of the patient. Auscultation is only practiced when complete muscular relaxation has been obtained. This posture has the effect of intensifying heart-sounds, and of showing the contraction. The author

wisely calls attention to the possible danger of this position in cases of pulmonary congestion, or pulmonary œdema, of acute endocarditis, ulcerative endocarditis, and of degenerative conditions of the heart. Azoulay states, frankly, that it is impossible to deny the fact that the "raised position" accentuates the normal and abnormal heart-sounds, and diminishes the heart-beats, more than the simple horizontal position, of which it is an exaggeration in point of weight, just as lying down is an exaggeration of the sitting or standing position. The "raised position" causes to appear, and to be heard distinctly, abnormal heart-sounds that cannot be heard at all when the patient is simply lying down, is sitting up, or standing. The intensity and clearness of these abnormal bruits is increased and brought out as in no other position, for the pulse is usually slowed, and thus it is possible to tell just when the abnormal sound begins.—*Medical Record*, June 24, 1893.

TREATMENT OF CHRONIC VALVULAR DISEASE OF THE HEART.—Dr. James Tyson discusses the various heart-tonics used in the treatment of chronic valvular disease of the heart. *Digitalis* is a remedy always better intermitted to obtain its best effects. He believes that the greater apparent efficiency of the infusion is partly due to the fact that it is generally given in larger doses; one-half ounce is not an infrequent dose of the infusion; this represents nearly 3 grains of the powder, or 20 minims of the tincture.

Of remedies which may be substituted for *digitalis*, *strophanthus* should, perhaps, be first mentioned—not that it is always the best. He has used it in doses of 10 minims, or 20 drops, every two hours for forty-eight hours, without interruption, and with good results. It is undoubtedly better borne by the stomach than *digitalis*.

Caffeine is an admirable heart- tonic in mitral regurgitation. One should not give less than 3 grains at a dose, seldom more, every three hours. When caffeine has been given in full doses for some time, it produces mental symptoms quite characteristic, consisting in hallucinations. They, however, cease immediately when the drug is discontinued. Another effect of caffeine, which sometimes interferes with its usefulness, is its effect in inducing insomnia.

Sparticne sulphate the author values very highly, especially where a diuretic effect is desired. The dose to rely upon is never less than $\frac{1}{4}$ grain, increased to $\frac{1}{2}$ grain, three, four, and five times a day.—*The Philadelphia Polyclinic*, June, 1893.

A CASE OF PARALDEHYDE HABIT.—When paraldehyde was first introduced, it was pointed out that one of the advantages of the new drug would be, that on account of its disagreeable taste and smell, a habit would not be likely to be acquired by those using it. Frank Ashby Elkins, M.B., recently presented the history of a case of paraldehyde habit, notwithstanding all unpleasantness. A summary of symptoms showed: *General symptom*, great emaciation; anæmia; slight rise of temperature in the mornings; *circulatory system*, heart's action weak and irregular; pulse intermittent and soft; palpitation; *alimentary system*, stomach derangement, especially flatulence; costiveness; boulimia; *respiratory system*, breath smelt of paraldehyde; *nervous system*, 1. motor symptoms; general muscular weakness, general tremulousness, especially in tongue, facial muscles and hands; gait feeble and unsteady; general restlessness. 2. Sensory symptoms, "strange feelings" running through body. 3. Mental symptoms, insomnia; great mental anxiety and agitation; discontent; unreasonableness; mental confusion; mental excitement; temporary loss of memory and incoherence of speech; shonting; tendency to strip himself; hallucinations of sight (he saw "strange beasts"); hallucinations of hearing (he heard his death would appear in to-morrow's paper, he heard his wife had said she wished he were dead); delusions (that he was being poisoned, that his milk was drugged with laudanum, that a woman was in his bed, preventing him from occupying it; that people were tormenting him, that the doctors meant to kill him, that the house was on fire, that harm was about to happen to him). It will be noticed that the hallucinations of sight and hearing, and the delusions, were all of an unpleasant character. The patient was three months under treatment, which resulted in recovery.—*Edinburgh Medical Journal*, July, 1893.

CHANCRE OF THE TONSIL.—Among the various forms of extra-genital communication of syphilis, that of chancre of the tonsil stands second only to that contracted on the lip. In the former locality it has often been overlooked, or has been diagnosed tonsillitis, diphtheria, and grippe. Inspection alone is not sufficient to determine the true character of the lesion, however; this will show a much enlarged tonsil sometimes projecting more than half way into the throat. The sur-

face of the tonsil is always very red, but the ulceration is not a striking feature; indeed, sometimes, there is very little loss of substance.

Palpation is the most important means of diagnosis, and should never be neglected. With the finger well guarded with carbolized vaseline, the examination will disclose a "stony hardness" of the tonsil. Epithelioma of the tonsil would simulate this hardness, but would be excluded by the age of early middle life, when most of these tonsillar chancres occur; also by the rarity of epitheliomata.

As in chancres elsewhere, there is commonly swelling of the nearest lymphatic glands, so in chancre of the tonsil we have the submaxillary glands involved on the affected side.

In certain cases the early skin symptoms are apt to be very light, and in instances have entirely escaped observation. In tonsillar chancre the eruption usually develops about the head and face first.

The syphilis arising from tonsillar chancre generally runs a very severe course, and in two cases where it was acquired by young ladies of highest character and position, from kissing those to whom they were engaged to be married, the course of the disease was frightfully severe. In regard to the modes by which the syphilitic poison reaches the tonsils in these cases, it is often very difficult to determine the matter with certainty. Many cases have occurred in aged persons from tasting the nursing bottle of a syphilitic infant. Many other cases occur from smoking-pipes, drinking cups, kissing, and, in men, sometimes from vile practices with their own sex.

The treatment of chancre of the tonsil does not differ essentially from that of syphilis in general. It is well to warn the patient against neglect of the case, and to carry out efficient treatment over a period of at least two years. Very great care should be exercised by the patient not to infect others, either from the local lesion, or the mucous patches in the mouth. Locally it is well to treat the sore here, as elsewhere, with occasional dustings of calomel; free garglings with saturated solution of chlorate of potash. Nitrate of silver, in solution of moderate strength, may sometimes be painted over the sore with advantage.—*Medical Record*, May 27, 1893.

RISES OF TEMPERATURE DUE TO DISEASES OF THE CEREBRUM.—W. Hale White, in a lecture on this subject, said: In the central nervous system are located three heat centres; one in the corpus striatum, the thermogenetic; another in the medulla and cord, the thermolytic, or that regulating the loss of heat; the third, thermotaxic, controlling the other two centres, is located somewhere in the cortex of the brain. By experiments on rabbits it has been proven that irritation of the corpus striatum causes rise of temperature; also, irritation or destruction of the cortex of the brain causes a rise, but not in every case. Clinically, therefore, we ought to find (1) that damage to the corpus striatum will cause a rise of temperature; (2) that damage to the cerebral cortex will do the same. As an illustration of the first, a boy was admitted to Guy's Hospital for right hemiplegia. His temperature varied from 102.4° to 106° or 107° F. At death, softening of both corpora striæ was found, and nothing else to account for the rise. From a number of cases treated at the above hospital, the following deductions were drawn: (1) If only one corpus striatum is damaged, the temperature will be higher on the opposite side of the body. The probable explanation is this: The heat fibres from the corpus striatum, like the motor fibres from the cortex, decussate. Thus, owing to the damage to the corpus striatum, more heat is produced on the opposite side in the muscles than on the same side. The blood, circulating through these muscles in which this increased thermogenesis is going on, is warmed, and therefore, of course, the temperature of the whole body is raised, but the rise is naturally greatest nearest to the source of increased heat. (2) If the case is one of cerebral hæmorrhage, for the first few hours there may be a considerable fall of temperature owing to the severity of the shock, but as the effects pass off the rise of temperature due to the damage to the corpus striatum will show itself. (3) In case of sudden damage to the corpus striatum the rise of temperature takes place quickly, usually attaining its maximum within twenty-four hours. It then slowly falls, the normal point being reached in a few days. (4) After it has reached normal it usually falls about a degree below normal, and remains subnormal for a few days before again attaining a healthy standard. When it is subnormal the temperature on the side opposite to a unilateral lesion is usually a little higher than on the same side. In cases of disease or

functional disorder of the cortex of the cerebrum, the temperature may rise very high, or it may be erratic, as in meningitis, a fact explainable not only by the exudate causing pressure on the cortex, but also that the sudden variations of it are caused by the fact that the meningeal inflammation disorders the thermotaxic nerve-cells, which normally maintain an accurate balance between the production and the loss of heat, just the same as it disorders the psychical functions and causes delirium. In favor of this view is the fact that in meningitis the rise of temperature bears no relation to the rapidity of the pulse or the frequency of the respiration, which suggests that the amount of heat produced by the body is not by any means correctly expressed by the rise of temperature, or, in other words, that the alteration of the temperature is due not to thermolytic or to thermogenic, but to thermotaxic, influences. As to functional diseases of the cortex, in epilepsy we find the temperature elevated after a fit, often to a very high degree. In hysteria the cortex is often disordered, and a rise of temperature may occur. We should be very cautious about entertaining the idea that a case of pyrexia is due to hysteria; it is a good rule to think of this disease last. Some of the characteristics of hysterical fever may be summed up as follows: (1) It always occurs in women. (2) They are often otherwise hysterical. (3) They are of an age at which hysteria is common. (4) The temperature is erratic and often attains a great height. (5) It may be different in different parts of the body. (6) The ratio of pulse and respiration to the temperature is often perverted. (7) The effects of antipyretics upon it is uncertain. (8) The other symptoms of fever, such as rigors, hot skin, and delirium, are often absent.—*International Clinics*, vol. i., series iii., 1893.

GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D.

TUMORS OF THE URINARY BLADDER.—Fenwick (London), in a clinical lecture, gives a review of this subject based upon one hundred cases.

The varieties met with in adults (in children they are sarcomata, inoperable and always rapidly fatal) are the benign (papillomata) and the malignant, which again may be divided into the succulent epithelioma of the mucous membrane which for a time resembles the villous papilloma, and the denser, rapidly destructive epithelioma which involves the muscular wall as soon as the mucous membrane. The benign constitute about one-fifth of these tumors.

Each of these groups presents a well marked clinical history. There is first a latent stage, during which the tumor attains a certain size; then appear hæmaturia, irritability of the bladder, and pain as a second stage. Papillomata and succulent epitheliomata of the mucous membrane both have the characteristic bloody urine, and of course this is the only stage at which operation can be undertaken in the latter. To this may be added vesical irritability and pain according to the location of the tumor. Scraps of tissue showing a "villous" character have no diagnostic value, as many (40 per cent.) vesical carcinomata have a surface covering of villous processes. Sooner or later both forms will enter on the third stage, that of cystitis. The duration of the second stage is much longer in benign than in malignant forms above mentioned, running into years instead of months. The deeper rapidly destructive epithelioma, begins with a cystitis, and is inoperable. Once cystitis has set in operation offers but little hope in any form of vesical tumor.

The only positive means of diagnosis is the cystoscope. A similar hæmaturia may occasionally be produced by prostatic congestions, by stone, by urethral caruncles in the female, and renal carcinoma or granular kidney.

In non-operative treatment the sound and catheter should be used with the greatest care, as the induction of the third stage, that of a cystitis, is above every thing, to be avoided. Hæmorrhage should be controlled by hæmostatics, irritability and cystitis by sedatives and supra-pubic or perineal drainage. If no infiltration can be felt through the rectum and cystitis has not developed, the sooner the patient is operated the better.

The route of election is the supra-pubic one, and when the bladder is opened and

the tumor located, a tubular vaginal speculum is pressed down around it and the contained water sucked out. By this method of "caisson working" the operator, with the aid of a head mirror or an electric lamp, has an unobstructed view of the tumor and its surroundings. It is twisted off with forceps and the base cleaned with scissors, sponge or knife. Hæmorrhage is arrested with a styptic and the bladder drained.—*British Medical Journal*.

TREATMENT OF NOCTURNAL ENURESIS.—Powers has used the following simple method with success: At the moment of retiring the orifice of the prepuce is sealed with collodion. If but little urine is passed the foreskin is found slightly distended. If the child is awakened by this distension he can easily remove the film of collodion himself. Cures have been made in two weeks.—*Journal of Cutaneous and Genito-Urinary Diseases*.

TREATMENT OF MALIGNANT TUMORS BY INOCULATION OF ERYSIPELAS.—Cooley (New York) records a series of cases in which an attack of erysipelas, coming on either accidentally or from inoculation, appeared to retard or arrest malignant disease. Injections of a pure culture of the streptococcus of erysipelas were made into the substance of the tumor. Such an artificial erysipelas is not a dangerous condition. When erysipelas was not produced, a febrile reaction (104°) lasting for one or two days usually followed. The effect of such injections is more marked when an erysipelas has resulted. In many cases the malignant growth appeared to be checked, and sometimes entirely disappeared. If recurrences followed, the inoculations were repeated. Occasionally erysipelas could not be produced. The action upon sarcoma is three times as great as upon carcinoma.—*American Journal of the Medical Sciences*.

TREATMENT OF INGROWN TOE NAIL.—Howard (Fort Worth, Texas) proposes a modification of the principle used by Cotting, who sliced off the whole side of the toe from the edge of the inflamed nail, the wound being allowed to heal by granulation, when contraction of the cicatrix drew the soft parts away from the nail. Instead of relying on the cicatrix to do this a wedge of the soft parts is removed so that by suture of the wound the same end is accomplished.

Commencing about three-sixteenths of an inch from the edge of the nail, passing the knife directly toward the bone, not going deep enough to wound the periosteum, the cut is made from the center in front, horizontal to the plantar surface, around and back to a line a little beyond the proximal end of the nail. Next beginning at the same place as before, the knife is passed in a semi-circular manner, ending with the proximal end of the first cut; by bringing the two incisions together at their deepest portion and two ends an elliptical wedge-shaped section is removed. Such a wedge when three-eighths of an inch wide is often sufficient to draw the soft parts away from the nail when it is closed by sutures. Primary union is sought for, and, in from a week to ten days, a shoe may be worn with perfect comfort. When both sides of the nail are ingrown, or the toe rises all around above a short sharply incurved nail, or one that has previously been excised, a wedge may be removed from around the entire end of the toe.—*New York Medical Journal*.

Another method that will answer in some cases consists of dusting the granulations and covering them with a bit of lint. Then a rubber bandage, fourteen inches long and half an inch wide, is carried from the well to the affected side, beginning at the extreme end, around and up the toe until the entire area of inflammation is covered. This tends to carry the inflamed mass away from the nail. The amount of pressure should be all that can be comfortably borne. The patient is then able to wear his shoe and go about his business, removing the bandage at night and re-applying it in the morning.—*New York Medical Times*.

EXCISION OF HYDROENCEPHALOCLE.—Mayo (Rochester, Minnesota) reports a successful case, which is encouraging in view of the gloomy prognosis in cases left to themselves, as well as in those treated by operative interference (Bergmann). This case with a few others recently reported (Horsley, Cabot, Mazzuchelli, etc.), tend to make the only operative hope less forlorn.

The patient, a child of one and a half years, presented a tender, pulsating tumor, that had grown from the size of a walnut to that of a small orange, in the median line of the occipital region. The cranial opening would admit the tip of the index finger.

The scalp was turned back, the dura freed to the bony opening, and the sac

opened, allowing the escape of about an ounce of cerebro-spinal fluid. Atrophied cerebral tissue was spread out on the inner side of the dura. The neck of the sac was ligated with heavy catgut, and the stump and scalp closely sutured. Vomiting and left-sided spasm followed the ligation and increased intra-cranial tension. Calomel was administered and rapid recovery followed.—*Annals of Surgery*.

TREATMENT OF SPRAINED ANKLE.—Gibney (New York) has applied with uniform success for four years a method suggested by Cotterell (London). The results are especially praiseworthy in that there is a minimum amount of enforced detention from the ordinary pursuits of life, and there is no tendency to a "stiffish joint" afterward. The method, which consists essentially of *strapping* with adhesive plaster and immediate continuous use of the limb, is carried out as follows:

Strips of rubber adhesive plaster are cut about half an inch wide and long enough to completely encircle the foot. These are then applied, one strip overlapping the other, beginning at the base of the little toe and embracing the foot, the ankle, and the lower third of the leg, until practically a Scultetus bandage is constructed. A gauze bandage is run up over the plaster to make it adhere closely, the stocking and shoe put on, and the patient instructed to walk about as usual. Recovery has invariably followed, without relapse and with an unimpaired joint.—*Polyclinic*.

We have practiced this method with most gratifying results, patients being enabled to attend to arduous duties without intermission.—*EDS*.

Barker (Morristown, N. J.) claims equally good if not better results, recovery being complete in three or four days from a different method consisting essentially of the prolonged use of hot water, careful finger-tip massage, flannel bandage over the entire foot, and use of the limb.

Hot water is continuously applied for several hours; this arrests the swelling, and is more soothing to the pain than the use of cold. The foot and ankle are snugly covered with a flannel roller bandage; this prevents further effusion, encourages absorption and supports the overstretched or torn fibrous structures. At least once daily the bandage should be removed and deep finger-tip massage practised wherever there is tenderness; this stimulates absorption and is very painful at first, but in a short time can be done by the patient. From the very outset the foot should be used as much as possible without great pain; besides the obvious advantages this improves the circulation.—*New York Medical Journal*.

IODOFORM OIL IN TUBERCULOUS JOINTS.—De Vos (Inaugural Thesis, Leyden, Holland) reviews the results obtained at the hospital and polyclinic during eighteen months by this method.

The emulsion is prepared as follows: ten grammes of iodoform powder are placed in a black glass bottle and covered with bichloride solution (1 to 1000) for four days. The powder is then thoroughly washed with distilled or boiled water; with these ten grammes are mixed by repeated shaking 100 grammes of sweet oil, which has been boiled for ten minutes and cooled to 30° C.

The following points of election for injecting the various joints are recommended after repeated cadaver experiments:

1. *Shoulder*.—The arm is adducted, the forearm being bent at a right angle across the abdomen, and the needle is introduced one centimetre behind and below the tip of the acromion process.

2. *Elbow*.—A point on the outer side of the olecranon, the needle going in between this process, the radial head and the capitulum humeri.

3. *Wrist*.—On the radial side at the dorsal edge of the styloid process; on the ulnar side at upper edge of the pisiform bone.

4. *Hip*.—A line is drawn from a point the breadth of the patient's thumb external to half way the distance from the anterior superior spine of the ileum to the pubic spine. From this point another line is drawn to the outer edge of the trochanter major. At the junction of the outer and second fourths of this line the needle is introduced, provided the limb is extended, the foot vertical, and the trochanter in its normal relation to Nelaton's test line.

5. *Knee*.—On the angle between the upper edge of the tibia and the ligamentum patellæ.

6. *Ankle*.—Immediately in front of the tip of the external malleolus, the needle being pushed between the astragalus and the malleolus.

Injections are to be made very slowly, not more than 10 c.m. in five minutes. As to the dose, one gramme of iodoform (in 10 per cent. to 20 per cent. emulsion) is sufficient for adults to begin with. This is repeated in a week if no reaction fol-

lows, and then every fourteen to twenty-one days, the iodine in the urine and persisting tender points being the guide.

In the after-treatment massage and passive motion are to be avoided, but moderate active movements are allowable. Several cases of intoxication were observed. Iodoform oil is considered far preferable to combinations of the drug with ether or glycerine. The duration of treatment varied from 9 to 325 days, the injections from one to twenty, and, as a result, 72 per cent. were cured, the ultimate results being better than those following erosion or resection.—*Centralblatt für Chirurgie*.

GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D. AND J. NICHOLAS MITCHELL, M.D.

THE TREATMENT OF CANCER OF THE UTERUS.—Winckel and Fritsch are of the opinion that total extirpation of the uterus should not be performed if the disease can be reached by the hot iron. Hertzfeld's method of extirpating the uterus by sacral resection has not met with much favor, and is to be used only in a very limited number of cases. Pfannenstiel, Winter, and others believe that recurrence of cancer after operation is largely due to inoculation of the wound with particles of the malignant tissue during the operation. Many prominent German operators believe that the tubes and ovaries should be removed in vaginal extirpation of the uterus. Fraenkel has abandoned the use of clamps in the above operation; the adnexa usually must be left, though he has had good results. He believes with Fritsch and Winckel that recurrence is much earlier after this palliative operation than after the safe method of curetting, cauterization, and the use of the hot iron. The fact that recurrence after using clamps takes place in the connective tissue and not in the cicatrix, as Landan states, is no argument for using clamps. The suffering of patients with such recurrences is often much more severe than in simple carcinoma of the cervix. Unless the operation can be thoroughly radical, vaginal extirpation should not be performed. Chrobak is of a similar opinion. He employs nitric acid and bromine for cauterizing, as they penetrate further than the hot iron. Säger recommends the removal of the cervix by the galvano-caustic method, and refers to the good results of Pawlik, Middeldorf, and Bryne; and after the slough has come away he advises further treatment with the chloride of zinc or nitric acid, which he believes a very valuable agent. Every nodule of recurrence must be removed promptly, and thus even radical operations easily may become radical. Olshemsen does not believe in inducing abortion for cancer of the pregnant uterus but in immediate operation—preferably, total extirpation. He only exceptionally removes the adnexa.—Transactions of the Congress of German Gynecological Society, May, 1893—*Centralblatt für Gynäkologie*, No. 23, 1893.

CASTRATION FOR OSTEOMALACIA.—A number of cases of this formidable disease have been reported as cured by this operation. The subject was discussed recently before the Obstetrical and Gynecological Society, in Vienna. Preindlsberger reported the following case from Professor Weinlechner's clinic. The patient was a multipara, 29 years old, with a good family history, and had always lived in circumstances affording good nutrition. Four years previously she became pregnant and could not raise herself. There were severe pains in the sacrum and thighs, particularly at the time of the menses. The pain, with difficulty in walking, increased, until finally she was not able to sit up, was much wasted away, and very anæmic. The pelvis and femora became much deformed. She was treated thoroughly with phosphorus for four months, without benefit. Castration was performed. The bone pains disappeared permanently on the second day after the operation, and in four weeks she began to walk and was discharged from the hospital cured, excepting the deformity. Professor Schanta reported that he had operated on many similar cases, and always with the best results. It was remarkable how soon the pains disappeared, and that it was so far unexplainable. He mentioned a case of Porro's operation where the ovaries were not removed, yet the result was the same. Last year Petrone stated, in an Italian journal, that osteo-

malacia was very probably dependent on an infection with the formation of nitrites and nitrates. It is recognized that osteomalacia occurs in individuals living in moist dwellings. Petrone has bred these organisms and caused infections in animals, with appearances analogous to those in man. He also observed that these organisms were destroyed by chloroform. He drew the conclusion that the remarkable results of castration were not due to the operation, but to the chloroform. He proposed administering chloral hydrate, which would charge the blood with chloroform. Schanta reported a case of castration with ether narcosis without any benefit to the osteomalacia.—*Centralblatt für Gynäkologie*, No. 18, 1893.

ÆTIOLOGY, DIAGNOSIS AND THERAPEUTICS OF GONORRHOEA.—In a paper on the *ætiology, diagnosis, and therapeutics of gonorrhœa*, Bröse arrives at the following conclusions:

1. Gonococci are undoubtedly the cause of gonorrhœa, but the microscopical examination is of slight value in establishing the diagnosis, as in many cases of gonorrhœa the gonococci cannot be identified, probably because they assume forms of involution. The culture test is the only proper method of making a bacteriological diagnosis of gonorrhœa.

2. There is no latent gonorrhœa in the male as assumed by Nöggerath and Tait. A careful examination of men who infect will invariably disclose inflammatory changes in the urethra.

3. The diagnosis of gonorrhœa in the female can always be made by careful observation of all the clinical symptoms without a bacteriological examination. The history of the case is of special importance as well as the careful examination of the male urethra or the vagina for the localization of the gonorrhœa.

4. The treatment among the married must cure both man and wife and if the man is incurable, it must be considered in treating the wife.

5. In curing gonorrhœa in the female it is quite as important to treat localization of it in the vaginal orifice as in the uterine cavity.—*Centralblatt für Gynäkologie*, No. 4, 1893.

GONORRHOEA IN THE FEMALE.—Wittie reports that in 1000 cases at Martin's polyclinic, there were 228 cases of gonorrhœa. The diagnosis was confirmed by the history, the anatomical alterations, the confession of the man and the statement of the woman that the man had a discharge. In 68 of these cases the diagnosis was confirmed by the presence of Neisser's gonococcus. Gonococci were found sixteen times in the vaginal secretion, forty-two times in the urethra, five times in the cervix, ten times in the pus of pyosalpinx. In 27 cases, eighteen women and nine children, examined for gonorrhœa, no gonococci could be found. Among the former were four pregnant women with urethritis and one girl with ovaritis, in whom acute urethritis suddenly developed while having intra-uterine treatment with iodine. The secretions of these cases were frequently examined but only flat epithelium, mucous corpuscles and diplococci were found, never gonococci. In 40 cases of vulvo-vaginitis in children between one and a half and thirteen years old, 22 were examined microscopically, gonococci were found thirteen times in the vaginal secretions.

The writer is of the opinion that the presence of gonococci in any secretion proves a gonorrhœal origin; that the absence of gonococci does not exclude gonorrhœa; in old catarrhs the gonococci are scarce, or may have disappeared and even then may recur.

The greatest importance must be attached to the anatomical alterations and complications which may occur with gonorrhœa.

In the 228 cases, there were 179 cases of vaginitis and among these there were 53 cases of vulvitis. Granular vaginitis was only seen in seven cases. Swelling of the inguinal glands occurred eleven times and only in acute cases. Bartholinitis was found twelve times. There was a suspicion of gonorrhœa in 28 more cases preceded by parturition, abortion, chancre or syphilitic infection. The writer considers the presence of condylomata acumidata one of the surest signs of gonorrhœa. They were found in 10 per cent. of the cases and twenty-nine times extended deep into the vagina as far even as the cervix. Urethritis was present in 225 cases, complicated twenty-five times by cystitis, partly hæmorrhagic, purulent or ichorous endometritis was presented in 65 cases and accompanied by erosion of the cervix in 26 of them. He was unable to state positively that the endometritis was always caused by the gonorrhœa.

Perimetritis was found in 56 cases—in 22 of them there was ovaritis; in 18, salpingitis, and in 16 there was a tubo-ovarian tumor, while parametritis was observed but twice. The last two cases were preceded by severe deliveries and fever in the puerperal state. The fact that perimetritis and ovaritis are so often found without salpingitis, is because the gonococci have not reached the peritonæum through the tube. One must assume, in these cases, that they have been carried by the lymphatics from the cervix to the peritonæum. This form of perimetritis is often accompanied by high fever, pain, nausea and vomiting.

Menstrual disturbances were present in 22 cases of diseased appendages. Women accustomed, previously, to flowing freely, regular and painless periods, now complained of very profuse flowing, irregular, and extremely painful periods, and often persistent metrorrhagia. There were three cases suffering in this manner without diseased appendages, and some cases of ovaritis and salpingitis without menstrual disturbance.

The prognosis of the above forms of gonorrhœa is serious, but not so unfavorable as might be thought, as therapeutics is not necessarily ineffectual. The observations of Bumm and Wertheim show that gonococci are very sensitive to depression of temperature, cooling of the room being sufficient to hinder their growth; also, that when their nutrition is lowered they assume involution forms not susceptible to staining, while culture tests in a good nutritive fluid will show the presence of gonococci. It is evident that these micro-organisms will degenerate in the tissue if poorly nourished, but revive as soon as an increased supply of blood improves the nutrition of the diseased organ.

The therapeutics requires careful avoidance of any injury which might produce congestion of the pelvic organs. If the adnexa are diseased, even where there are marked inflammatory symptoms, provided there is not destructive suppuration, the inflammation usually can be cured in a few weeks by blood-letting, ice-bags, rest in bed, and regulation of the diet and bowels, followed, later, by very careful applications of iodine to the uterine cavity after curetting the endometrium. Laparotomy is a last resource in comparatively few cases of pyosalpinx and ovarian abscess.

The writer submitted the following conclusions for discussion:

1. Vulvo-vaginitis in children frequently depends on gonorrhœa.
2. Gonorrhœa often runs its course without ascending, and is sometimes cured by simple cleanliness.
3. Bartholinitis seldom depends on gonorrhœa, but on some other infection, from parturition, abortion, soft chancre, or syphilis.
4. Colpitis granulosa is a rare complication of gonorrhœa. The condylomata acuminata are among the best anatomical signs of acute and chronic gonorrhœa.
5. Disease of the appendages are cured by proper treatment, if there is not suppurative destruction of tissue as in pyosalpinx and ovarian abscess.—*Centralblatt für Gynäkologie*, No. 4, 1893.

EXTRACTION AFTER SYMPHYSEOTOMY.—Professor Schanta has found that severe lacerations along the anterior vaginal wall and urethra easily occur during the extraction of the child, and cause dangerous hæmorrhage. He recommends very slow extraction in such a direction as to bring the least pressure on the soft parts, at first downwards and backwards, and to support from the beginning the soft parts anteriorly, similar to the support given to the perinæum. Great care is necessary in the final delivery of the head, as the usual support of the pubic arch is lacking, and the hand should be used to take its place as a fulcrum. Perineal lacerations are far less dangerous, and are preferable, even with extensive episiotomy, to lacerations anteriorly.—*Ibid.*

DRAINAGE IN PELVIC SURGERY.—No method of drainage in pelvic surgery is comparable to the glass supra-pubic tube aided by suction. The tube should be smaller than Keith's modification of Koeberle's tube. While the length of the tube should vary to suit the depth of the pelvis, the diameter should be one-half of an inch, with open end and numerous perforations. The tube should be placed in position with great care. Passing two fingers to the bottom of the cavity to be drained, the intestines are carefully held aside and the tube held in position, the outer end being in the lower angle of the wound while the surgeon is closing the incision and completing the toilet. The tube should be carefully emptied before the dressing is fastened. A piece of dental rubber dam, twelve inches square, punctured in the centre, should be passed over the collar of the tube, a handful of ab-

sorbent cotton or gauze placed over the end of the tube and the four ounces of the rubber brought over and primed. A towel is carefully placed over all. To facilitate the gravitation of the fluid toward the hollow of the sacrum the outward flow should be made as free as possible. In order to promote rapid occlusion of the general peritonæum from the drained area, and perfect drainage, the tube and tract must be frequently cleaned. This can be best accomplished by a long-nozzled syringe. When the drainage is profuse the tube should be emptied at first every fifteen minutes, gradually increasing the interval as the quantity of discharge diminishes. The tube should be cleaned every hour during the first six hours after the operation. Every hour or two, when cleaning the tube, the nurse should gently elevate in a minute degree the end of the tube and rotate it, to keep it full and patulous. The dressings should fit around the collar of the tube snugly, and, if coiled, they should be changed. The nurse should never leave the patient alone while the tube remains in the abdomen. The time for removal of the tube is when the discharge ceases, generally inside of thirty-six or forty-eight hours. When the tube is removed a saline purgative should be administered, so that supplementary drainage may be had through the intestinal tract. When necessary, a small rubber tube may be passed through the glass tube and the glass removed, leaving the rubber in the drainage tract by way of precaution. This should be done always when the tube is removed under thirty-six hours. Where the rubber tube is made to replace the glass tube in this way, it should be drawn up and cut off half an inch or more daily to secure gradual closure from the bottom.—L. S. McMurty, M.D., *American Journal of Obstetrics*, 1893.

UTERINE, AS A CAUSE OF BREAST DISEASE.—Dr. Routh sent to the International Congress at Brussels a brief *résumé* of three cases illustrating the relation of the uterus as a causative of breast disease. In the first there was immense hypertrophy of the parenchyma of both mammæ from uterine irritation; the second, hypertrophy of the cervix, in whom both mammæ were as big as a man's head but large from the size of the lacteal tubes, and not involving the parenchyma. Amputation of the cervix immediately brought about absorption of the mammæ to their normal size. The third was a well-marked cancer of the breast, which he amputated. But although the greater part of the wound healed, for weeks small cancerous points kept cropping up. The other breast becoming painful, Dr. Routh insisted upon a vaginal examination, and found the uterus intensely ulcerated inside the cavity and outside on the cervix. He cured the ulceration, and no further cancerous points made their appearance. He considered, therefore, that in all cases of mammary disease the uterine organs should be examined and treated, if found diseased. Baker Brown believes that many cases of enlarged breast could be traced to irritation of the vulva or cervix uteri.—*The British Gynecological Journal*.

THE TREATMENT OF VOMITING IN PREGNANCY.—R. Frommel recommends a base of orexin (Phenyldihydrochinazolin $C_{14}H_{12}N_2$), which does not have the unpleasant taste of orexin. He has treated four women, between twenty and thirty years old, with it; two were first pregnancies, one a second, and one a third; two were in the third month, one in the fourth, and one in the fifth month of pregnancy. The multiparæ stated that they had vomited previously throughout the entire period of pregnancy. All four were promptly cured by this remedy. Two of the women entirely stopped vomiting on the second day, and the others within fourteen days. Equally good results were obtained by Dr. Gessner in a severe case at the sixth month. The dose of the orexin base is 0.3 two or three times a day in a gelatin capsule. The preparation is made by Kalle in Bieberich.—*Centralblatt für Gynäkologie*, No. 16, 1893.

SYMPHYSEOTOMY.—Leopold states that symphyseotomy should be performed in all cases when the child's head is movable above the pelvic brim and when heretofore perforation of a living child would be considered, i.e., a narrowing of the conjugata vera of 7.5 to 6.5 cm. The requisite conditions are, fever must not be present, the child must be alive, the pelvis must not be contracted obliquely from ankylosis. Leopold hopes by symphyseotomy to limit the perforation of the living child to the advantage of the infants and to limit the relative Cæsarian section to the advantage of the mothers.—*Centralblatt für Gynäkologie*, No. 16, 1893.

MONTHLY RETROSPECT OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D., AND FRANK H. PRITCHARD, M.D.

A COLCHICUM PROVING BY ABSORPTION.—Agricola gives us his unique experience with this drug as follows: Having met with a floral oasis of autumnal crocus in a wild forest, I gathered a quantity of the bulbs, most of which were an inch in diameter. Upon my arrival at home, I removed the outer scales and roots, bisected the bulbs, and put about a pint into a jug and covered them with glycerine; then in an hour transferred them and the glycerine, which had now become as fluid as water, into a quart pickle bottle, which I filled with alcohol. During this process, some of the glycerole got on my hands, and, in a fit of abstraction, I mechanically spread it over their whole surface by rubbing my hands well together. Suddenly it occurred to me what would probably follow, i.e., absorption into the circulation of a dangerous cathartic, and therefore immediately immersed my hands in water and dismissed the subject from my mind. About two hours later, much abdominal flatus compelled me to take a promenade, while two hours still later I experienced sensations under the liver whereby I knew that sharp purgative action was in progress, and soon afterward felt cathartic action in the rectum. For one hour I took *camphor* tincture by finger tips every five minutes, which effectually arrested the cathartic action. However, during the night and early morning there remained occasional abdominal disturbances, flatus, pelvic tenesmus, etc., and constipation which lasted through three days.

I have had numerous other instances proving the power of *camphor* to arrest promptly the pathogenetic action of drugs, but the present is the most instructive. The symptoms of impending disturbance were so energetic as to render it prudent for me to give to those around me instructions as to what to do in case danger to life should arise.—*Homœopathic World*, June, 1893.

COMPARISON OF CROTALUS AND LACHESIS.—These two remedies resemble each other in many particulars, yet the differences are sufficient to distinguish between them. Both cause symptoms of prostration and shock; disturb the moral and intellectual faculties; produce hæmorrhages from all the orifices and into the skin; disorder digestion; disturb the urinary and sexual functions, the respiratory organs, the heart; cause fever; produce inflammations, ulcerations, and gangrene; all kinds of nervous sensations; aggravation of symptoms after sleep, and intolerance of tight clothing around the waist. *Crotalus* has not the intense sensitiveness of *lachesis* entering into all its conditions, and the aggravation after sleep is not nearly as marked as with *lachesis*. The mental symptoms are much alike; both have irritability and loquacity, but *crot.* is more snappish than malicious. *Lach.* does not know what time of day it is; *crot.* does not know where he is in the street. *Crot.* is markedly a right-sided remedy; *lach.*, markedly left-sided.—*Ibid.*

CROTALUS AND LACHESIS IN JAUNDICE AND YELLOW FEVER.—*Crot.* has a much more predominating action on the liver than *lach.*, hence its greater appropriateness in yellow fever and some conditions of jaundice. The hæmorrhages, calling for its use in yellow fever, are more marked in *crot.* than in *lach.* There is flow of fluid blood from all orifices of the body. (It has also been successfully employed in the hæmorrhagic diathesis.) There is bilious vomiting brought on by lying on the right side; sticking pain in the epigastrium; inability to bear tight clothing; pains in the liver; black "coffee-ground" offensive stools. In *lach.*, the blood is like charred straw. *Crotalus* has yellow color of the skin and hæmorrhages into the skin.—*Ibid.*

NAJA IN HEART AFFECTIONS.—The heart gives the most characteristic indications for *naja*. Almost every other affection is accompanied with heart disturbance. In diphtheria the heart is threatened. Crampy pains in the left ovary are accompanied by severe palpitation. Symptoms produced by grief are felt in the præcordia and back. There is dyspnœa, which is of cardiac origin. An irritating, sympathetic cough attends some organic diseases of the heart.

In the heart itself the following symptoms are noted: Depression and lowness about the heart; sensation as though a hot iron had been run into the heart and a hundred weight put upon it; severe pain in the left temple, cardiac and ovarian regions; sensations as if the heart and left ovary were drawn up together; angina, pains extending from heart to nape of neck, left shoulder and arm, with anxiety and fear of death; aggravation at night, and from lying on left side.—*Ibid.*

NAJA IN HEADACHES.—The characteristic headache of *naja* is a pain in region of the left orbit, extending back to occiput; preceded and followed by nausea and vomiting. It is of intermittent character, occurring every second or fourth day. Headache at menopause, aggravated after sleep. There is also great mental depression and melancholy; suicidal insanity, brooding over imaginary troubles; effects of great grief. Great talkativeness.—*Ibid.*

HÆMORRHAGES OF ELAPS.—The coral snake venom, like others, causes hæmorrhage; but the bleeding of elaps is distinguished from the rest by being the blackest of all. There is a profuse flow of dark blood at the menses and between the menses. The menses recur every two or three weeks. In hæmoptysis there is black blood after conghing. There is a taste as of blood before hæmoptysis.—*Ibid.*

ELAPS IN DISEASES OF THE EAR, NOSE AND THROAT.—There are illusions of hearing, buzzing, crackling, deafness; otalgia of right ear, a discharge which leaves a green stain on linen. Catarrh with black wax; tinnitus; otorrhœa—offensive, yellow, green, liquid and bloody. Intolerable itching in ears.

The nostrils are plugged with lumps of dry mucus; sleeps with mouth open. Offensive discharge; posterior wall of throat covered with dry, greenish-yellow scab, wrinkled and fissured, extending up to nose; nosebleed, with pains from root of nose to ears on scabbing, loss of sense of smell. Discharge smelling like putrid herring brine; coryza from the least draught of air. Black blood flows in steady stream; arterial blood gushes from ears and nose.—*Ibid.*

REMEDIAL TREATMENT OF ACNE.—In seeking for the indications for a given case of acne, we are obliged to look for the subjective symptoms apart from the skin, and usually in those parts or tracts where dwells the primary cause of the disease. Hence, *belladonna*, *borax*, *iris ver.*, *kali bi.*, *ledum*, *psorinum*, *nux vom.*, *hydrastis*, *lyc.*, *puls.*, *cantharis*, the *mineral acids*, etc., are frequently indicated. In their pathogenesis they may show papular eruptions as with *borax*, *bell.*, *nux vom.*, *hydrastis*, *puls.*, *canth.* Where the reflex character of the affection is clearly established, the cutaneous lesion is of minor importance as a therapeutic guide, and often may be left out of consideration in making a prescription. The drug should be selected which has such eruptions as prominent features of its pathogenesis, unless by some idiosyncrasy of the patient another remedy is indicated, in which case it will be the more effective one. The following drugs produce papules and pustules, and are of medicinal value in about the order named: The *bromides*, *sulphide of calcium*, the *iodides*, *arsenic*, *sulphur*, *iodoform*, *chloral*, *antipyrine*, *cantharis*, *copaibia*, *cinchona salts*, *bell.*, *antim. tart.* and *borax*. Some show a more or less pronounced affinity for the skin of the face and shoulders, or where the sebaceous glands are abundant, and where acne commonly appears; such drugs are the *bromides*, *iodides*, *calcium sulphide*, *chloral*, *bell.* and *borax*.—*North American Journal of Homœopathy*, June, 1893.

THERAPEUTICS OF CHOLERAIC DIARRHŒAS.—*Aconite*.—Scanty, loose, slimy or mucous stools. Hands and feet icy cold with blue nails; icy coldness over whole body; cold, clammy perspiration.

Arsenicum alb.—Scanty and excoriating stools; slimy green; mucous; black, like dirty water; sometimes very offensive. Vomiting of water, bilious or slimy green, brown or black masses. Violent burning pains in the abdomen. Cramps in the calves, twitching of the muscles. Icy coldness of the skin and clammy sweat.

Camphor.—Sometimes scanty, rice-water stools, with marked nausea. Cramps

in calves; pain in the pit of the stomach; cutting pains with stools. Hands and feet are icy cold, extremities cold and blue with cramps; coldness of body, dry or in a cold sweat; coldness after vomiting.

Carbo veg.—Cheeks and finger-tips icy cold, lips bluish, cold breath and cold tongue. Indicated especially in the last stage when the cramps, general reaction, and discharges up and down, have ceased.

Croton tig.—Yellow-colored water, or watery stools, mixed with whitish flakes and gush out like a shot; worse after eating or drinking. Violent vomiting of ingesta; sudden attacks of vomiting, fluid yellowish-white and frothy.

Cuprum.—Profuse gray, watery stools with flocculent matter, gushes out as a stream. Constant vomiting of frothy mucus or bilious matter; vomiting water after slight nausea accompanied by lachrymation. Spasms in muscles, first in lower limbs, then in upper ones, then in muscles of abdomen and chest; violent cramping in stomach. Collapse, with coldness, blue surface, cold breath and cold tongue and death like prostration; coldness all over.

Jatropha cur.—Easy vomiting of a watery substance like albumin. Violent cramps in lower limbs; calves flat like splints. Marble coldness of the body; sticky, cold perspiration.

Phosphorus.—Stools light colored or greenish, with small white particles or sometimes undigested food; profuse, watery and pouring as if from a hydrant. Violent thirst for cold water, but vomits it immediately, or as soon as it becomes warm in the stomach.

Veratrum alb.—Green, watery stools mixed with flakes; profuse rice-water discharges which gush out like a stream with considerable force; generally inodorous, and contains mucus, sometimes involuntary. Violent vomiting with continued nausea and great exhaustion. Vomited matters are bile-stained, yellowish-green, foamy, sometimes containing undigested food. Cramps in the calves, violent colic around the umbilicus as though the abdomen would be torn open; abdomen sensitive to contact with drawing and cramps in the fingers. Icy coldness of the body; cold tongue and breath; cold feeling in abdomen, nose and face cold; cold sweat.—*Ibid.*

AN ARSENICUM CASE.—A child of five years ate heartily of canned fish for supper and went to bed apparently as well as usual. Shortly after midnight her parents were aroused by her cries; she was suffering from an intense pain in the stomach, and soon vomited profusely. The pain and vomiting continued at intervals through the remainder of the night. In the morning a "regular" physician was called; he prescribed something to "settle" the stomach and "soothe" it, and ordered milk and lime-water as nourishment, which was promptly ejected. No improvement following, he continued the above and ordered enemata of boiled starch and laudanum. The child was growing steadily worse when the writer was summoned on the fifth day. There was extreme tenderness in the region of pylorus on slightest pressure; thirst was constant and intense; pulse, 140; temperature, high; there was constant agonizing nausea, the stomach not retaining even a few drops of cold water. All previous treatment was ordered stopped, and the patient was given *arsenicum alb.* 3x trit., one grain every two hours. For nourishment, the mother was ordered to give her a teaspoonful of mutton-broth every three hours; small bits of cracked ice were recommended to allay the intense thirst. At the second visit there was a marked improvement, there had been no vomiting since the first dose of medicine. The mutton-broth had been retained and relished. There was less pain, and for the first time since being taken sick, a few brief intervals of refreshing sleep had been enjoyed. The same medicine and nourishment was continued, milk being added later. A complete and uninterrupted recovery was made in a few days.—*Medical Century*, 1893.

TREATMENT OF INFLUENZA.—Dr. Gisevins, of Berlin, recapitulates the results of his experience in the epidemics of 1889-90 and 1890-91. There is no prophylactic against the disease.

Aconitum 2x. Slight cough, rhinitis with moderately serous discharge; then catarrhal fever, dry, hot skin and glowing hot face, rapid rise of temperature, great thirst, pulse very full and frequent with the heart-beat very much increased. The patient is seized with a syncopal weakness. Dryness and irritation of the upper air-passages, voice hoarse and dry cough.

Bryonia, 1x, 2x. Violent epistaxis, intense inflammation of the nasal mucous

membrane, cough, either dry or with mucous, muco-purulent or blood-tinged sputa. Pains in the pleura at every movement or breath, the anxious, short respiration sometimes passing on to dyspnoea. Complete anorexia, tongue heavily coated, taste, bitter or putrid, with a foetid odor from the mouth. Nausea and even vomiting; obstinate constipation; violent headache, backache and lumbar pains. The patient feels depressed, and is completely without strength. Insomnia, vertigo, the fainting attacks increase and delirium may even be present.

In most cases these two remedies will bring about recovery with the production of bad-smelling sweats. Eczema of the mouth and nose may accompany and extend over the whole body.

China, 1x. Extraordinary weakness with depressing and exhausting sweats. The patients resemble those who are recovering from an attack rather than patients who had passed through an illness of three to four days. A search of the literature does not reveal this remedy to have been used in this stage before. The patients are in a state of physical and mental depression. They have attacks of vertigo and fainting, aggravated on leaving the bed. Sleep does not refresh them, their pulse is weak and small, the heart-beat very feeble; substernal irritation. The larger bronchi are filled with accumulations of mucus; anorexia with a bitter papery and insipid taste. Tongue coated, thirst, dyspepsia. Sometimes diarrhoea would serve to further weaken the patient. All writers admit the tediousness of this stage which rapidly disappears under china every two to three hours.

This is the typical course of the disease. Often, deviations required other remedies.

Belladonna, 3x-4x.—Dry cough with violent burning in the trachea, the cough at night assuming a spasmodic character, dependent upon an inflammatory irritation of the larynx, so that it was often confused with whooping cough. The submaxillary glands and tonsils and pharyngeal mucous membrane swell so that violent dysphagia sets in. The headache increases to intolerance, and is aggravated by every movement, talking or a light. Somnolent conditions with confused dreams. The patients get delirious as soon as they close their eyes. Profuse secretion of tears, while the conjunctivæ are greatly injected. They have a staring look, so that an attack of cerebral irritation is to be feared. If this fail, then give stramonium 3-4x.

Arsenicum, 4x.—Moderate fever and severe rhinitis, with profuse thin secretion, so that the nostril and upper lip are eroded, with violent headache. The pains radiated from the forehead into the temples and even the face. The pulse from the beginning is not much increased, but in elderly people very weak, with restlessness and anxiety, and occasional angina pectoris. Insomnia, unusual corporal weakness, depression, with painfulness of all the limbs.

Rhus Toxicodendron, 3x.—Restless sleep, with involuntary deep respirations and restlessness which allows of quiet in no position. Tearing, fixed, drawing pains, especially from the neck into the arms, down the back into the lower limbs, associated with a torturing feeling of coolness. Sensitive to every change of temperature after being wet through.

Eupatorium Perfoliatum, 3-6x.—Bone-breaking pains, with pains in the back. The catarrhal symptoms are less prominent. Though the joints are sometimes swollen, the extremely violent pains are generally situated near the ends of the bones at the epiphyses. If an exanthem be present after fall of the temperature, it is either scarlatiniform or pustular, and the remedy is the more indicated. Not much sweating, and after acon., bry., bell. or gels. have removed the fever. It resembles china in the great weakness.

Complications and After-Affections.—Circulatory disturbances are rarely mentioned in homœopathic literature. Cardiac weakness was observed in both the old and young; in the latter it being chiefly due to excessive doses of antipyrin (and other coal-tar remedies.—EDS.). Ammon. carb., cactus grand., spigelia and dig. were useful here.

Respiratory Complications.—Mangan. acetic., hepar s. c. and iodium were of service in chronic inflammatory complications with hoarseness and burning and pain in the larynx and dyspnoea. Phos., in alternation with tart. emetic. gives good results in bronchopneumonia after capillary bronchitis. Kali hydriod. is useful in the stage of hepatization of cyclic croupous pneumonia. As soon as lysis sets in, then give tart. emetic.

Intestinal Complications.—Nux vomica was sometimes required.

Urinary System.—Milk diet, rest in bed, canth., coccus cacti, nitric acid.

Hæmorrhages from different organs are sometimes observed which yield to phosphor., ferrum mur., hamamelis, or sulphuric acid.

Conjunctivitis is with obstinate corneal ulcers and photophobia is now and then observed, yet they yield to arsen., bell. or mercur. precip.

Nervous diseases often complicate. *Kali hydriodicum*, 1-2x, cures the neuralgias of the sciatic nerve, gels. those of the trigeminus, when the pulsating radiates into the forehead and eye from the occiput. *Stram.* is of value when unbearable pains occupied the entire head with great nervous irritability and twitching in the facial muscles as in tic convulsus.—*Zeitschrift des Berliner Vereines Hom. Ärzte*, XII., Hft. II.

CHENOPODIUM ANTHELMINTICUM.—In a study of this drug in which but little that is new is developed, two interesting cases of poisoning are described. A man took a half ounce of the tincture and felt the effects of narcotic-acrid poisons. It affected his brain, spinal cord, and stomach. He was found insensible, convulsed, and with foam at his mouth. Another individual took an ounce and a half of the oil and experienced the following: Nausea, vertigo, deafness to the human voice, he could hear some distant sounds; aphasia; impossible to control his voluntary muscles, a sense of weight and heaviness in the muscles. Hilarity, or desire to laugh at trifles; rejects things like a drunken man, convulsions and paralysis of the right side, involuntary emission of urine; foam at the mouth, profuse sweat, icterus and death, preceded by a comatose state, on the fifth day after its ingestion. It is recommended as a vermifuge and in disturbances of the nervous system as described in the poisoning case. It is superior to other worm remedies as merc., sulph., etc. Its analogue is *santonine*, which causes epilepsy, convulsions, depression of mind, delirium and great agitation. Besides the nervous symptoms, *chenop.* causes cutting pains in the abdomen, especially worse at night, with flatulence and desire for stool, hoarseness and burning in the throat, secretion of frothy mucus in the mouth, heaviness of the head and constipation. In verminous affections it has been used in doses of one to three drops of the mother tincture every three to four hours on sugar. In nervous troubles employ from the 3x to the 12x.—*La Homœopathia*, Nos. 18, 19, 1892.

A CASE OF VOLVULUS.—Dr. W. Heyberger records a case of volvulus in a woman of 38 years following an attempt to help push a wagon. There was a tumor in the abdomen to the right of the umbilicus, circumscribed and hard, from which the pains, with burning and contraction of the intestines, radiated. Vomiting; distorted and pale face. *Atropine* 5x relieved the pain, and *nux vomica* 3x, every half hour, together with *thuja occ.* 3x, on account of the twisting pains in the abdomen, and ice-cold compresses, produced a marked change in the patient; the tumor relaxed and became less painful, the pains nearly entirely disappeared, she became quieter, the vomiting ceased, her thirst lessened. The same treatment was continued, and on the third day the tumor and pains had disappeared, and with that she had had a stool.—*Allgemeine Homœopathische Zeitung*, Nos. 13, 14, 1893.

PASSIFLORA INCARNATA.—Dr. Seiffert publishes a study of this drug, which is almost unknown in France. He fixes the indications as follows: It produces calm and restorative sleep, which persists after cessation; it is not a narcotic, but exerts a curative and not a palliative action. (?) It is of excellent service in sleeplessness from mental effort, delirium tremens, neuralgia, neurasthenic patients, (?) and the morphine habit after suppression of the drug. The size of the dose varies—10 to 20 drops of the tincture, according to some authors, and 60 drops to a spoonfull, according to others.—*Revue Homœopathique Française*, November, 1892.—[We have used *passiflora incarnata* in a case of obstinate insomnia of neurasthenic origin, with unsuccessful results. It was given in doses varying from 10 drops to 2 drachms. It seems to be a drug which is lauded by a few drug houses, upon the testimony of a very few and vague observations.—EDS.]

MERCURY IN THE TREATMENT OF DIPHTHERIA.—During the initial stages of the attack, *belladonna* and *phytolacca* are given, but if decided improvement does not follow in a day or two, *merc. cyan.* 6x trit. is prescribed. This is coupled with a very frequent spraying of the throat with *bichloride of mercury*. In four or five cases this treatment did very well, and seemed to combine the specific action of the *merc. cyan.* with the local antiseptic action of the corrosive sublimate. By using the 1x dilution of this powerful drug, it is very easy to make a solution of the desired strength, say 1-1000 or 1-4000. The last mentioned is strong enough, and safe to use at short intervals for a short time. The amount of spirits of wine used with it can

also be varied. This also is powerfully antiseptic, besides being useful as adding a little alcohol to the treatment. Glycerine added to the spray makes it fairly pleasant even for young children, and this also is solvent and antiseptic.

For the swelling of the tonsils and cervical glands, *merc. bin.* 2x and 3x trit. was given; while for the debility and anæmia *iron* was given. In one case where the fetor of the breath was a striking symptom, *baptisia* acted quickly and beneficially.

The internal treatment by *merc. cyan.*, combined with the local spray of *merc. corr.*, seems to offer a simple and successful plan for attacking this dire disease in many cases at least.—*The Monthly Homœopathic Review*, July 1, 1893.

CASE OF ANÆMIA CURED BY GRAPHITES.—Miss D., aged 20 years, of soft fibre inclined to be stout, and had red hair. She looked absolutely bloodless. Her feet are swollen. For fourteen months she had not menstruated. The family had been in much trouble, and the girl had been in a situation that was too heavy for her. When her monthly periods first came on she had an extensive open running sore at the back of the head, which lasted for some time before it healed. The immediate symptoms for which relief was demanded were a constant pain in the temples as from knives, and pains in the back of the head, vomiting, and a constant feeling of sickness. There were loud murmurs all over the cardiac area. The urine contained phosphate but no albumin. The bowels were constipated. She was very chilly and sensitive to cold,

The medicine indicated by the most urgent symptoms—vomiting, nausea, pain in the head—was petroleum, which also has a very definite relation to the anæmia and is, besides, allied to graphites, being one of the carbon group. Petroleum given in the third trituration acted very promptly. The pains in the head ceased, the sickness vanished, and the following morning she had an appetite. The headache, however, did not go. Accordingly, she was given graphites 1m. Under this remedy (aside from a dose of kreosote given for intermittent toothache, she made a good recovery —Dr. John H. Clarke, in the *Homœopathic World*, June, 1893.

STANNUM.—The stannum patient is sad and of a weeping disposition, worse from crying, in this being like *natrum mur.* There is weakness, nervousness and irritability. She can ascend the stairs better than she can descend; when she goes to sit down she just drops into the chair. In dyspepsia, there is nausea and vomiting; even the smell of food causes vomiting. There is a weak, gone feeling in the abdomen. The rectum is inactive, causing much straining to evacuate even a soft stool.

The menses are too profuse and too early, and are preceded by melancholy. There are pains in the malar bones during the menses which are relieved as soon as the flow begins.

A characteristic symptom in lung troubles in which stannum is indicated is despondency. This is unusual to find in consumptives, for, as a class, they are the most hopeful patients to prescribe for. The coughs in stannum are in fatiguing paroxysms; there is tickling as from soreness down the trachea; constant inclination to hack as from too much mucus in the chest: dry cough in the evening in bed; concussive paroxysms of three coughs each, caused by mucus and by stitches in the trachea, with copious green, salty expectoration most profuse in the morning. Scraping cough with greenish, offensive expectoration of a sweetish taste; worse in the evening before lying down, with a hoarse voice. Sore sensation in the trachea and chest after every cough.

Stannum is useful in the first stage of consumption when a neglected catarrh or grippe threatens to pass into phthisis. The patient cannot talk long at a time for want of breath; there is more or less aphonia; roughness of the throat and sore pain in the chest; feeling in the chest after coughing as if it were deprived of its contents; profuse night sweats; the arms become easily fatigued, so that they drop anything they may be holding.—*North American Journal of Homœopathy*, July, 1893.

PROVINGS OF BETONICA AQUATICA.—Transient aching stitches in right temple. Pressing pain in left temple and forehead. Inability to concentrate the attention, as if memory was failing.

Loss of appetite; feeling as if something were stuck at lower end of œsophagus, with a slight feeling of nausea and "heartburn."

Transient pains in abdomen, in hepatic region and region of the transverse colon.

A sharp pain, then a duller pain in the region of the gall bladder and below the left breast. Sharp, shooting pain in the right inguinal region. Sharp stitches in the left groin which pass up nearly to the apex of the heart. Also aching in the spermatic cords, especially the right, with weakness across the small of the back.

Shooting pains, also throbbing in the back of both wrist joints; occurs every two or three seconds, and causes a weak paralytic or helpless feeling in the wrist joint and hand. The wrist "drops" and the fingers hang down limp, particularly the index finger. Pain at the lower end and inner side of both femora, just above the condyles. Sharp shooting in right popliteal space down the leg to the heel; the leg feels as if paralyzed and gives way when walking, thus simulating symptoms of popliteal aneurism.—*Homœopathic World*, July, 1893.

CINA.—This drug is pre-eminently a child's remedy. In febrile conditions the cheeks are very red, while the upper lip is of a peculiar bluish white. This latter symptom is not found under any other remedy. A *cina* child will pick and bore at its nose; it is cross and irritable, don't want any one to even look at it. The patient cries for things which are pushed away when offered; it cries to be carried and will not sleep unless thus humored. The *cina* diarrhœa is often white mucus like popped corn. The urine turns jelly-like or milky on standing. In whooping cough, the child, if in bed, rises suddenly to a sitting posture, looks about wildly, becomes convulsively rigid, then the cough follows. *Cina* is sometimes needed to complete the cure of a case of whooping cough, after *drosera*. During sleep, grinding of the teeth, tossing about with crying and complaining of colic, are indications for *cina*. In cases where *cina* fails when indicated, *silicea* is often required to complete the cure.—Prof. A. McNeil, M.D., in *Pacific Coast Journal of Homœopathy*, May, 1893.

KALI BICHROMICUM IN A CASE OF ASTHMA.—Mr. S., a shoemaker, has suffered from asthma seventeen years; his condition was so aggravated at night that he was obliged to sleep in a reclining chair. Having taken a severe cold, his sufferings were greatly intensified and the following symptoms presented: Continuous cough, hard and dry, the face becoming purple; crowing inspiration; the expectoration difficult, color bluish white, and so stringy that the handkerchief was required to remove it from the mouth. *Kali bichromicum* 3x was given in water, a dose every two hours. The next day he went to his work free from asthma for the first time in years. He has had no recurrence of the attacks for nearly six months.—*Pacific Coast Journal of Homœopathy*, May, 1893.

A CASE OF COPPER POISONING.—A girl, æt. 24, was employed for five years at weaving the insulation on copper wire. A great quantity of minute particles of the metal floated continuously in the air, sufficient to require the floor to be swept twice daily.

While at her work, without any warning, she fell in a "fit" accompanied by intense griping abdominal pain; frothing at the mouth; unconsciousness, and involuntary passage of urine and feces. On return to consciousness came recurrence of the pain which threw her into another convulsion.

Dr. J. M'E. Ward, who reports the case, was called in two weeks after the onset of these attacks and found her intensely nervous, desiring constant motion of hands and feet; wanted to go somewhere, or do something all the while, but motion aggravated all her symptoms. When standing or walking, her knees would "give out," and she would fall. The abdominal pain seemed to concentrate at the middle of the transverse colon. She had frequent attacks of nausea and retching, better from lying down and fasting; coppery taste, foods all tasted alike; tongue coated light brown down centre; mouth dry, no thirst; painless diarrhœa, not exhausting, felt better after a passage. The menses had been suppressed for five months; there was leucorrhœa and pruritis.

Hepar 12, four doses daily, was given as the antidote and continued for five weeks with excellent results. One dose of *puls.* served to re-establish the menstrual function in three days. The nervous and gastric symptoms were successfully treated with *nux vomica*. From this time to the end of the treatment she received *hepar* 30, with occasional doses of *ign.* and *dulc.* as the symptoms required.—*Homœopathic Physician*, May, 1893.

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HOW SHOULD HOMŒOPATHIC MATERIA MEDICA BE TAUGHT?

BY "X."

IN curing the sick by the use of drugs according to the Law of Similars, it is required that the leading, characteristic, and distinctive features of a disease shall be matched by the leading, characteristic, and distinctive features of a drug-action on the human organism, as determined beforehand by careful experimental use upon one or more healthy persons.

The carefully noted records of these experiments constitute pure materia medica from the homœopathic standpoint.

In the practical application of this method, it is desirable; First, to have as many reliably tested drugs as possible at the command of the physician.

Second, to have the results of these experiments in the most readily available form for immediate use.

These points may be even more tersely stated; it is desirable to have a reliable materia medica; it is desirable that it be immediately available.

That teaching which most nearly equips a student of materia medica after this manner, is the most desirable teaching for practical purposes.

As often happens in things human, the realization of this ideal is

far from complete. Effort should therefore be directed toward supplying as far as possible the deficiencies arising under these demands.

The reliability of our *materia medica* will not be discussed in this place. The theme is too vast. Suffice to say, no man is fitted to teach this most important branch of healing, without fully realizing the reliability, and the unreliability of what he teaches. Lack of information here is worse than a blunder; it is a fraud.

To meet the second demand above-mentioned, that physician who has the largest number of drugs clearly fixed in his memory, as to their characteristics, leading, and distinctive features of action, has the most readily available *materia medica*.

On the other hand, the man who has to consult his books rather than his memory, either from lack of application, or from any other cause, has healing resources of a much less available order. He may be just as reliable in the end, and in some cases even more reliable, but he is much less available in practical healing.

Now it so happens that the field of homœopathic *materia medica* is already so broad, and the effects of certain drugs upon the healthy human organism, as determined in many instances, is so comprehensive, that no one mind is capable of holding all the facts well in hand at one time; it is a human impossibility.

Hence the consultation of books is a necessity, at least for confirmation, in some cases. In difficult or obscure cases, it will be well-nigh inevitable.

We have here two conflicting interests, we might almost say conflicting facts, if that be possible.

In view of this conflict, some teachers have, unwisely as it seems to me, advised that the homœopathic physician always consult his books, and never trust to his memory in any instance.

The vast difference in immediate and constant availability between a reliable and well-stored memory, and a library of books is so great, that no one should abandon the use of the former, at an earlier point than is absolutely necessary.

Since, however, a compromise must be made at some point, it seems to me better that the memory be required to do all that can reasonably be expected to do, and books used to supplement the rest.

How to make this first and best resort available to the greatest extent, should be the sincere effort of every instructor in *materia medica*; how to consult books should be his second care.

In considering the first, it is important to note, that all memories are not equally retentive, and therefore it is a false plan of teaching

that adapts itself only to one class of minds, especially so, when the class addressed is of the highest average type.

While this class of students may benefit from such teaching, a very large class flounder hopelessly under burdens they can by no expediency be made to bear, and end in mediocre disgust, with all attempts to memorize *materia medica*.

To avoid such a calamity, for it is nothing less, to the future physician and to the community to whom he is to minister, the laws of acquisition must be clearly understood, and constantly kept in mind.

The more important of these laws may be briefly summarized as follows:

First. Memory is limited in its scope, even in the best cases.

Second. Only those things are available in memory, which are clearly comprehended.

Third. Acquisition proceeds from one fact to another, until several have been acquired before generalizing. Many violate this law, by teaching generalizations at first, and the facts on which they are based afterwards, thus getting the cart before the horse.

Fourth. Constant repetition is the price of fixed impressions.

The only exception to this law is, where the first impressions are very vivid. One heavy blow may accomplish what only many lighter ones can consummate. It is not possible always to get in the heavy blow.

At this point some important things are obvious, to wit: no teacher of homœopathic *materia medica* can take up the drug-list and go through it from A to Z, in rotation, talking against time and distance, with profit to himself or his students. Such a course is an absurd waste of time and energy.

While any new drug that presents a new combination of characteristic effects well substantiated, is always a welcome addition to homœopathic *materia medica*, still the limits of memory forbid attempting to hold in mind more than a certain proportion of drug facts.

If now the drugs known to homœopathic *materia medica* be roughly classified as well proven and partially proven, we shall have a useful distinction.

As a rule, the well-proven are those that had best be taught. Again, these may be further subdivided for convenience, into drugs of large and small range.

Other things being equal, that drug had best be memorized which is most likely to be frequently available.

The polychrests are such a class. In making out a list of such

drugs as are most likely to be in frequent demand, few if any will be found outside of this class that are worthy of special mention, and from this class are to be selected all drugs to which the teacher calls especial attention.

I will hazard the assertion that any method of teaching that widely departs from these principles will prove fundamentally wrong and productive of imperfect results. In furtherance of these views, I submit the following general plan for teaching homœopathic *materia medica*.

A list of not above twenty drugs should be chosen, regard being had to the breadth of their sphere of action and reliability of original provings and clinical confirmations.

In the first treatment of this list, only the leading characteristic and distinctive symptoms should be mentioned and dwelt upon. As one drug after another is thus mastered in its essential outlines, each new drug is compared with those already known through previous study, and their resemblances and differences carefully compared and as carefully noted. By these steps, gradually taken with slowness and precision, we lay a lasting foundation of knowledge in homœopathic *materia medica*. The law of similars admits of this strong assertion, since well-established drug-effects upon the healthy admit of change only when the nature of the drug is changed, or the nature of the human organism becomes different from its present constitution.

When twenty drugs have been mastered after this manner, they should be immediately restudied and a wider range of symptoms included. In this second study, not all the recorded symptoms will be noted by any means, but only such as have undoubted clinical confirmation in many instances. By the time this group has been carefully gone over in the second course, the student will be in condition to attack the final group. Not above eighty or one hundred drugs should be included in the latter. One by one they are studied, first and distinctly, as to characteristics; second, as to confirmed symptoms; always in comparison with cognate drugs already known, none others being mentioned.

When this second course is brought to a close, the third will be taken up after this manner.

The hundred or hundred and twenty drugs are studied as exhaustively as time and circumstances will permit. Good examples of this kind of teaching are Dunham's or Farrington's lectures.

When one hundred drugs have been mastered after this fashion, the student may safely be given his diploma. He has all and more

than he can hold in memory, and he may safely be trusted to add to his knowledge such other drugs as the emergencies of his practice may demand.

During the third course the repertories and the leading text-books have been in constant use. Their arrangement and reliability has been a constant theme in the course of each lecture, and complete familiarity has been attained with their use.

The student, now familiar with all standard works, is perfectly able to cope with any new drug he may have occasion to employ, having learned how to master it in its essentials and its details.

He will have gained also what is more essential—a sound method of comparing drugs and prescribing them, which is the end of all teaching in materia medica.

Nothing has thus far been said of clinical teaching. It should go hand in hand with every step above described.

When the student has thoroughly mastered the leading characteristics of half a dozen drugs, it is time for him to listen to clinical prescribing. When he has gone over the first twenty in the second course, it is time for him to try his hand at prescribing, subject to the revision in all cases of his instructor.

By the time he begins the third course he should be required to make at least one prescription every day or two. He should keep a careful clinical record of every case for which he prescribes, noting every change for the better or the worse, following the administration of the drug, and reviewing practically the points laid down in the *Organon* of Hahnemann for the administration and repetition of the remedy.

Not until he has started upon the path of pure scientific investigation in these respects; not until he has learned to distinguish a drug aggravation from a progressive stage of the disease, is he a physician.

Finally, in consulting books as aids to memory, he will be required in the third course to investigate authorities. Every homœopathic college should have a large consulting library, embracing, as far as possible, copies of original provings and original authorities. Many duplicate copies should be constantly on hand and of ready access. Such a course as this would stimulate the sifting, confirming and definite establishment of the status of all doubtful or rare symptoms.

It would breathe into the rank and file of the profession the spirit which now infuses the few, those who labor to-day to elevate the healing art to the rank of an exact science.

PYROGENESIS.

BY SAMUEL N. WATSON, A.M., M.D., IOWA CITY, IOWA.

THE investigations of medical scientists have long been directed to the solution of the various problems that fever presents—what process does it represent in physiological functioning, what is the relation to the healthy or diseased condition of the human organism, what is the correct attitude of the medical attendant toward it as expressed by his treatment, and what is the scope of drug action in relation to it.

Physically, fever simply means increased body temperature. With a surface temperature normally ranging from 98° F. to 99° F.—with an average temperature of 98.4° F.—any rise above 99° F. is likely to be the beginning of fever, and a temperature of 100° F. is always fever.

Physiologically, the definition of fever becomes more difficult. Certain facts, however, are indisputable. Increase of functioning means rise of temperature, whether it be by stimulation of the assimilative function, stimulation of the circulation, or that compensatory stimulation of the whole vegetative sphere which results from the interference with its normal action. It seems no longer possible, in the face of well-known facts, to limit the pyrogenic function to certain nerve-centres or even to the nervous system in its entirety. While the irritation of certain nerve-centres will undoubtedly produce fever, yet it is but a temporary increase of temperature, and can no more suffice to produce a definite febrile process than will the puncture of the floor of the fourth ventricle produce a permanent diabetes. This fact, together with other general indications, notably the well-known rise of temperature after death following certain pathological conditions, points to the field of origin of the pyrogenic process as situated within no circumscribed limits in the organism, but rather in all the tissues in the body, wherever organic metabolism is going on. The mind of the scientific world to-day seems to be swinging back to the old idea that heat means combustion, and that increased heat means increased combustion, and that fever is accelerated consumption of the albuminoid products, accompanied by heat production and bodily waste.

The pathological definition of fever, while by no means easy, is somewhat limited by the points already made. The theory that

fever constitutes the pathological essence of any disease has long since passed out, and with it the term "essential fever." To-day fever is recognized in all cases to be a symptom only, a token of the reaction of the system against some hostile influence, an outward expression of the disturbance caused in the general metabolic process by the intervention of some traumatic, chemical, micro-biotic, or other pathogenetic factor. We see in inflammation the same process on a small scale that we see in fever on a large scale. There is a local disturbance of equilibrium in a circumscribed area of the body, caused by some destructive agency; at once there is a migration of the leucocytes, which have also a phagocytic function, into the tissues of the affected part; the local temperature increases comparatively to the temperature of the organism as a whole, and with this there is an increase of functional metabolism and a corresponding tissue change. In like manner, fever is the expression of the work done by the organism—probably in all of its parts—in an attempt to convert, repel or oppose some pathogenetic factor which has disturbed its normal functioning.

While the phagocytic theory in its present form cannot be held to be absolutely demonstrated, yet some form of it seems so inherently likely that it makes it the best working hypothesis that we have. From a biological standpoint it seems natural, not that there should be a special leucocyte which alone has a phagocytic function, but that all the body cells, nerve cells, connective-tissue cells, pulmonary cells—all alike are able, at a sufficient stimulus, to react against any invasion inimical to their well-being, and, by displaying increased activity, metamorphose or expel the *materies morbi*. The external indication of this unwonted energy we call fever.

So far, then, from fever being of the essence of disease—a thing to be combated and put down by any possible means, irrespective of the general systemic condition of the patient—it seems far more likely that fever, while undoubtedly indicative of the presence of disturbed function, is yet itself but one of the necessary conditions of recovery, *i.e.*, the restoration of the function to its norm. It is the earnest of recovery, the indication that the system is reacting against the disease-poison, and the proof that it is able so to react.

Such being the pathology of fever, considered as an entity for purposes of definition, it is evident that the fever is not the disease, nor yet the cause of the disease, as variously considered in time past; nor yet does the fever constitute the real danger to the patient. High fever is undoubtedly a real danger in itself, inasmuch as it

represents an enormous amount of misdirected energy, and inasmuch as it is generally accompanied by an enormous amount of tissue-waste ; yet, none the less, the fever and the waste of which it is indicative are but expressions of a morbid process, and not the process itself.

From a therapeutic standpoint, therefore, treatment which is directed primarily at the fever without regard to the morbid agent or the morbid process of which the fever is an exponent, regarding it simply as fever and nothing more, and considering the office of physician to be fulfilled when the fever is reduced, is comparable to the effect of firing at the cap held up by an enemy on the end of a stick instead of at the man below it. It is an undoubted fact that fever is a source of suffering to the patient, and that the suppression of the fever will give relief, while the system will generally proceed by processes of excretion, slower and less certain, to expel the offending *causa belli* ; but if this suppression be by a general antipyretic directed simply at the fever—in the light of facts a vicious therapy—the patient is worse off, so far as his general systemic condition is concerned, than if he had been left to nature's unhindered efforts ; this if the antipyretic works successfully ; yet in how many cases does the antipyretic fail of its mission and simply serve to poison the organism to a greater or less degree, thereby depressing its vegetative activity ! Modern therapeutics has largely exercised itself in the search for an absolutely certain and universal antipyretic ; it has been the following of an *ignis fatuus*. The universal antipyretic has not been found and will not be found, and would be of no real value to suffering humanity if it were found. Such therapeutic agents as the coal-tar compounds, when used as antipyretics, were lauded to the skies when first discovered, but are passing out of use more and more among the most intelligent of practitioners, as they see their ill-effects in many cases and suspect it in others, and recognize the fact that while they do depress the heart-action and promote radiation, they do not, as a rule, exert a favorable influence on the course of disease, in other words “do good to the patient.” Therapeutics must assimilate itself to the discoveries of pathology if it is to retain the confidence of either doctor or layman. It must set itself to perfect its knowledge of those remedies which will aid the system in its efforts to expel the *materies morbi*, and which strike at the root of the disease, not at its manifestation, instead of searching for new means to depress and paralyze its vegetative activity.

Fortunately, the method of search and the line of investigation

have already been indicated. There are two well-known remedies in certain conditions of the highest value as true and rational antipyretics, yet which in another sense are not antipyretics at all, which admirably illustrate the point. I refer to the action of cinchona in certain malarial fevers and to the action of mercury in syphilitic fever. There is no therapeutic theory which ignores these invaluable agents in the conditions mentioned, and their distinct relations to the pathological conditions indicated are among the axioms of practice. But, as has been said, in the strict sense of the term, these drugs are not antipyretics at all. For (I quote from Cantani), "they are useless against other fevers, and even in malaria and syphilis they abate the fever, not because they are antipyretics, not because they can depress the bodily temperature, and can restore the febrile metabolism to its normal condition, but because they abolish the action of the specific cause of a specific fever, *i.e.*, the fever itself." The full terms of the relationship between cinchona and the paludal cachexia or the developed malarial fever, or between mercury and the syphilitic poison we are not in possession of; but certain things we do know, cinchonism is a condition of the organism in which the red blood-cells have been and are being destroyed in great numbers; the same condition obtains in the malarial fevers. An unknown disintegration of the vital fluid producing ulcers of mucous surfaces, caries of bone, and enlargement and destruction of glandular tissue is the effect of mercurialization. A markedly similar process is the result of inoculation with the syphilitic virus. And, furthermore, dynamic doses of mercury will subdue the syphilitic fever and check the tissue-destruction that accompanies it; and dynamic doses of cinchona will check the fever of malaria and restore the color of the blood. It is not necessary to dogmatize about the method of this action; but until some better explanation of it is produced than the law of similia, we cannot rationally escape from accepting that.

The ætiological treatment of fever, therefore, having been shown to be not the reduction of temperature by depressing the systemic functioning at any cost to the patient, but rather such an aiding of this reaction of the organism as will most speedily render the pyrexia useless and spare the system the necessity for this unusual labor by opposing force with force; it may be of value to glance briefly at the fever-armamentum which is at the physician's disposal, and indicate on the basis above suggested the drug-action of some of the fever remedies.

As fevers are commonly classed as *sthenic* and *asthenic*, so the drugs which are most commonly applicable to the rational treatment of fevers may be classed under two heads: 1. Drugs which are pyrogenetic by virtue of their effect upon the circulation, either by direct stimulation of the circulatory apparatus or by paralysis of the vaso-motors; 2. Drugs which cause distinctive blood changes, and whose pyrogenetic property is due to the effort necessary on the part of the organism to overcome the destructive process which they initiate. As an example of the first class aconite is the type; and arsenic is the type of the second class.

As an antipyretic and antiphlogistic aconite, has been in continuous use in homœopathic therapeutics from the earliest years of the present century down to this day, and has well won for itself the title so often given it of "the homœopathic *lancet*." At the present time it is in use by all schools of medicine, although as late as 1874 Ringer says: "Its virtues are only beginning to be appreciated."* Aconite is not a primary pyrogenetic; it produces no marked blood-changes, and a casual glance at its action would lead one to suppose that it was a mere cardiac depressant; in fact, it is often so regarded. Such, however, is not the case. Its first action is seen in the rigor or chill which it causes through its effect upon the vascular nerves. Under its influence the arterioles contract to produce the cold stage; then becoming paralyzed dilate helplessly, and the storm of arterial excitement sets in, and we have the typical "synocha" of the old authorities. It is neither toxæmic nor sympathetic, but purely neurotic. During the time of the external chill the temperature is really rising, as has been proven by numerous experiments, notably those of Erman; and the experiments of Dr. Mackenzie showed a thermometer in the ear of a rabbit to rise from 2 to 4 per cent. under its influence. In saying that the fever of aconite is neurotic the whole scope of the drug as an antipyretic has been covered.

The direct opposite of aconite is the representative which was mentioned of the true pyrogenetic, arsenic, called by the learned Hughes "the greatest of medicines because the greatest of poisons." It will be well to note first the characteristic marks of arsenic as displayed in its effects upon the human organism when taken in toxic doses, effects which show plainly enough its distinct toxæmic febrigenic character. There is a well-marked periodicity in the return of the symptoms caused by the drug; the condition induced

* *Handbook of Therapeutics*, 4th edition, *loc cit.*

is markedly adynamic, great prostration and weakness resulting, anxiety and restlessness intensified by burning pains and ceaseless thirst—all these, together with the hopelessness of the individual himself present a perfect picture of a febrile toxæmia. This is the condition set up in chronic arsenical poisoning. Reliable evidence goes to show that arsenic can also give rise to a fever which is simply symptomatic of the gastro-intestinal disturbance that sets it up; this, however, is not the true toxic exponent of the drug, but rather that kind of a fever described by Von Grauvogl as produced by it, having associated with its initial stage vaso-motor spasms like aconite, but speedily passing on to a picture of the remittent or typhus states. Arsenic is, therefore, an antipyretic of the widest possible scope, ranging therapeutically from the symptomatic fever of gastric irritation or the hectic of tuberculosis to the malignancy of typhus or the putridity of pyæmia or septicæmia. Its mode of action is best indicated by Ringer, who calls it a protoplasmic poison.

Regarding the two foregoing remedies from the standpoint of comparative therapeutics, it may be said that aconite is ephemeral, arsenic is protracted, aconite is neurotic, arsenic is toxæmic, aconite is superficial, arsenic reaches to the inmost depths of the pyrexial process.

Another typical toxic agent capable of producing a true primary pyrexia is baptisia tinctoria. Its first effect is seen in a burning heat of the whole surface, especially the face, full, soft pulse, and hot, dry tongue, a condition soon followed by intestinal congestion and catarrh, with abdominal tenderness. Here is a distinct toxæmia of a peculiar type, *congestion* being its chief mark, the blood rapidly disintegrating and becoming dark and thick. Hence the well-known therapeutic applicability of this drug to the earlier stages of typhoid, or even to the later stages if the congestive symptoms continue to predominate.

Space forbids the mention of but one more antipyretic agent in detail, and that is a drug which cannot well be omitted from such a comparison as the foregoing, belladonna. In the sthenic class it is the analogue of baptisia in the asthenic. Its synonym is also congestion—active, however, not passive. Its action on the human economy is twofold: first, paralyzing the inhibitory fibres of the pneumogastrics, and secondly, stimulating the sympathetic system peripherally, it becomes of therapeutic value in dynamic doses in a vast array of fevers, in inflammations and neuroses, all characterized by congestion and violence of the pathological process. In all the

toxic effects which it presents, whether the disturbance be motor, sensory or mental, there is constant evidence of the coexistence of active determination of blood. In the sensory sphere it is marked by hyperæsthesia, in the motor sphere by jactitation, in the mental sphere by delirium. It is therefore an antipyretic of extended range. In the febrile processes where the excessive oxidation that may be held to be the chemical equivalent of the pyrexia falls chiefly upon the nervous centres; as Hughes says, "where there is too much blood-poisoning for aconite to act, but not enough to require arsenic, and where the disorder of the vegetative life for which baptisia is indicated is less prominent than that of the nervous centres," there we find the type of fevers for which belladonna is the unfailing antipyretic.

Enough has been said in the brief comparison of the four drugs given above to indicate the meaning of the ætiological therapeutics of fevers, and especially to contradistinguish that method of treatment from the crude habit of practice which, while admitting pathologically that fever is not of the essence of disease nor yet a disease in itself, does yet proceed forthwith to treat it as such, distinguishing in no respect one fever from another, but simply seeking to depress temperature by the use of the fashionable antipyretics and antithermics of the manufacturing chemists' invention, and thereby disregards and bankrupts the ever-active resources which the system possesses within itself for the resolution of forces inimical to its proper functioning. The constant effort of the scientific physician is directed not toward reducing the fever as such, but rather by the discriminating use of such remedial agents as will assist nature in maintaining the systemic equilibrium to render the pyrexia useless at the earliest possible moment.

The words of the learned Boerhaave are much to the point: "*Quid est febris? Est naturæ irritatæ conamen ad expellendum stimulum inconsuetum.*"*

STREPTOCOCCI AND LACTIC ACID.—Witte has found that streptococci cannot endure 0.07 per cent. of lactic acid, but staphylococci can as much as 0.5 per cent. The acid of the vaginal secretions amounts to 0.95 per cent. so that it must be diminished one-half for the development of staphylococci, and to 0.07 for the growth of streptococci. Cocci grown in acid cultures showed diminished virulence.

These observations are of importance in connection with those of Döderlein respecting the inhibitory action of acid secretion on pathogenetic bacteria in the upper third of the vagina.—*Centralblatt für Gynäkologie*, No. 13, 1893.

* Indebtedness should be acknowledged to the admirable monograph on "Antipyresis," by Prof. Dr. Arnaldo Cantani (Naples), published by Wm. Wood & Co., New York.

ARBORIVITAL MEDICINE.

BEING AN INQUIRY INTO THE CURATIVE POWERS OF SOME OF
OUR COMMON FIELD AND GARDEN PLANTS, JUDGED
OF BY THE DISEASES OF THE EAR.

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VIOLA ODORATA.

THE purpose for which this investigation is undertaken is to ascertain indications which will enable us to take a glance of the true curative force of plants, and which I assume to be growth-force, so as the better to apply this force to the dispersal of disease. The idea is to investigate, not for the purpose of overthrowing,—the iconoclastic conception of the modern penny-a-liner,—but to investigate for the simple purpose of utility. Consequently, I am quite as prepared to inquire into the action of an unproven drug as into that of one whose action has been fully investigated, *more homœopathico*.

The common violet has been very fairly proved, and has long counted amongst our remedies. We have had its proving long enough before our eyes if a proving and a proving alone is all that is necessary for the successful application of a drug for chronic disease. This is just what I question. Every proved drug in our pharmacopœia ought to be reinvestigated clinically from time to time, and investigations ought to be undertaken from every possible quarter and under every possible variety of condition. Dr. Drysdale's investigations into the action of kali bichromicum was in every way a gain, and seemed to exhaust the subject, but more recent inquiries from an allopathic standpoint into its action show how impossible it is to say the last word upon the action of any drug. My inquiry into the curative power of the common single-flowered, dark-colored, scented violet was undertaken from a few flowers, buds, stalks, and leaves purchased in the street, and from which my tincture was prepared. It did not take long to convince me that in the violet we possess an undoubted power in the treatment of ear cases. The action of the violet upon the ear is more regularly demonstrated in ear diseases than, I make bold to say, that of any known drug, and for this reason: If *viola o. φA.* be given in a case of otorrhœa,

where the discharge has ceased for some days or even weeks, and where the ulceration of the ear is still unhealed, the effect is to cause an immediate discharge from the ear with very probable improvement of hearing, or if the ear be actively discharging a contrary effect—a drying up—ensues. This has occurred so often in my practice that I unhesitatingly put it forward as a test of the accuracy of these researches. It is of course quite possible that in the hands of others such a uniform result will not follow upon the immediate exhibition of the remedy. All I ask is that fair play be dealt out in making trial of this property of the violet, and fair play requires that trial be made upon several cases, for obviously all patients are not equally susceptible to the action of a remedy.

Quinine and other drugs in large doses set the ears a-buzzing, and while in deaf cases satisfactory recovery of hearing follows upon the exhibition of such remedies as *calcareo carb.*, *hydrastis can.*, *calendula offic.*, etc., not one of these is followed in small and single doses by an absolutely demonstrable and immediate result upon a diseased ear. I therefore claim for *viola odor.* a unique, special, and pronounced effect upon the ear, such as no other drug hitherto introduced possesses in the same demonstrable fashion. The claim is a tremendously important one, and I mean, in making it, to throw down the gauntlet, and to invite the most strenuous opposition from all observers. Let there be no mistake about it; the claim is a definite one; let others prove, if they can, its inadmissibility. If, then, the administration of *viola* be succeeded by a result so definite and so frequently observed, it will follow that this must be from a special pathological disturbance created by it.

Let us then work the matter out. Toynbee (*The Diseases of the Ear*, Hinton's edition, 1868, H. K. Lewis, Gower St.), at page 312, writes: "The effects of chronic disease in the mastoid cells upon the lateral sinus and cerebellum are: 1. Suppuration in the lateral sinus with or without secondary purulent deposits. 2. Inflammation of the dura mater and arachnoid and the formation of pus upon the surface of the cerebellum. 3. Abscess of the cerebellum."

In the *post-mortem* room, then, suppuration of the lateral sinus is found to be one of the most frequent pathological changes present in middle ear disease, with or without cerebellar suppuration; in other words the lateral sinus, with the inferior cerebellar veins, and the other connected sinuses, the petrosal, cavernous, and circular sinuses are specially liable to be disturbed in suppurative conditions of the middle ear with mastoid cell involvement.

This is precisely the tract upon which *viola odorata* acts, the discharge that succeeds its administration being due in the first instance to the disturbance of the lateral sinus. In dormant suppurative ear-disease, we find a precisely similar occurrence to follow upon fatiguing railway and other travel, the cerebellar veins and lateral sinus being we may assume, in these cases specially disturbed.

The provings of *viola*, archives of staff, bring into singular prominence a great amount of eye disturbance, and though the ear symptoms are fewer, they are none the less significant. Here is verbatim, the symptoms as taken from Curie's Edition of Jahr's *Homœopathic Medicine*.

Head.—Dull and painful confusion in the head. Turning vertigo, also when seated. Cephalalgia, sometimes with cramps in the eyes, and luminous circles before the sight. Heaviness of the head with sensation of weakness in the muscles in the nape of the neck. Congestion of blood to the head, with prickings in the sinciput. Tension in the integuments of the head, extending into the face, nose and ears, frequently forcing one to knit the brows. Burning in the forehead.

Eyes.—Cramps in the eyelids. Closing of the eyes as from a sleepy sensation in the eyes and eyelids. Heaviness of the eyelids. Sensation as if the eye-ball were compressed. Heat and burning sensation in the eyes. Myopia. Flames before the eyes.

Ears.—Shootings in the ears. Aversion to all kinds of music, principally the violin. Roaring and tickling before the ears.

Nose, etc.—Torpor in the end of the nose as from a blow. Pain in the face with drawing pressure in Zygomatic process. Tension in the integuments of the face especially above the eyes. Tearings in the lower jaw in the direction of the ear.

To my reading these symptoms point in the direction of congestion of the base of the brain, with a strong leaning to nerve involvement, especially of the retina. The principal indication I have relied upon in giving *viola odor.* in ear cases, is a tendency to pain immediately above the eyebrows, and affecting both sides of the forehead; the knitting of the brow, the burning of the forehead, the tension especially above the eye, the prickings in the sinciput point in the proving to this, and this easily remembered symptom has enabled me to individualize with success when a more certain inquiry into the symptoms was impossible. The patients who have been benefited by *viola*, are dark-haired subjects with neuralgic, side-by-side with congestive symptoms; the appearance and dispositions of the patients

are very similar to those that derive benefit from *ferrum picricum*. Contrasted with *agrophis nutans*, the difference is very striking; *agrophis nutans* benefits light-haired persons, with bronchitic history or a history of other catarrhal affections and a tendency to mucous flux of all kinds with but few localized symptoms; whereas the *viola* patient is dark-haired and the symptoms were strongly localized to the ear and the supra-orbital and orbital regions.

There can be no mistaking the cases. To give a few cases:

CASE I.—A pale anæmic dark-haired young woman of 20, admitted May 21, 1892, with deafness of both sides, which dated from influenza complicated with bronchitis and pneumonia six years ago, left ear being the worst. Symptoms: roaring noise in both ears, worse on meditation; often has headache through the temples and behind the eyes, bowels confined, appetite very bad, catamenia regular. Both *mœ. ti.* more anæmic than normal, otherwise no alteration. H. D., R. 1, L. off.—*Viola odorata*, φ A.

July 9, 1892. Ears about the same, tinnitus same; headache less; bowels better, appetite very bad. H. D., R. 3, L. 2½. The improvement in the hearing and in the headache led me to believe that the remedy had "gone home," and so another drop of the same was given. She remained then without medicine until next seen, October 1, 1892, when her condition was altogether changed for the better; she heard much better, the pains in her head were less, and the tinnitus almost gone, bowels still obstinate. H. D., R. 8 ins., L. 6 in.

This was really a very obstinate case of deafness and interested me particularly. I specially inquired into her history with a view to ascertaining what treatment she had had for her ears, but could only elicit that she had been treated for inflammation of the lungs and cardiac disease, of which the deafness was the accompaniment, but that her doctors had not attempted to deal with the hearing. On examining the heart I could find nothing more important than slight enlargement and overaction. On this occasion, the 1st of October, I gave a third dose of one drop of the *viola*, another on the 5th of November, a third on the 19th of November, and a fourth on the 3d of December, the hearing on this last occasion being 9 in. on right and 4 on the left side, and conversation hearing being good and in every way serviceable. After this she ceased attending. In the above case the involvement of both eyes and ears with accompanying headache led me to select *viola odorata*, as previously explained. And a like consideration influenced me in the

next case, which, strangely enough, presented itself at the London Homœopathic Hospital on the same day, 21st of May, 1892.

CASE II.—A dark-haired girl, rough skin, bilious complexion, age 13, deaf on both sides after chicken-pox four or five years ago, with otorrhœa, and increasing myopia, subject to violent headaches after exertion or excitement, poor appetite, regular bowels. H. D., R. $\frac{1}{2}$ in., L. off contact barely, large perforations in both ears. R., *viola odorata*, φ A.

11th June, 1892. Altogether improved, headache less. H. D., R. $2\frac{1}{2}$ in., L. $2\frac{1}{2}$ in. No medicine.

2d July. Eyes much better, sees clearer, ears have been discharging for the last two days a good deal, at times hears much better. H. D., R. $2\frac{1}{2}$ in., L. $\frac{1}{2}$ in., *viola odorata*, φ A.

16th July. Eyes better, no headache, very little discharge from ears, sleeps much better, used always to wake at 4 or 5 A.M., but never does so now, hearing certainly better. H. D., R. $2\frac{1}{2}$ in., L. $2\frac{1}{2}$ in. No medicine.

6th August. Ears discharging a great deal, had one bad headache, but the duration of it less than usual. H. D. as above. *Viola odorata*, φ A.

17th September, 1892. Enthusiastic report; in every way better. H. D., R. 7 in., L. 5 in. *Viola odorata*, 6th cent. dil., one drop for a dose.

1st October, 1892. In every way brighter and better, ears discharging much less (the discharge used to pour out), eyes are better, and the perforations in the mœ. ti. look clean and are healthy. H. D., R. 5 in., L. 6. No medicine.

15th October, 1892. Still improved, can hear all sorts of things in the house she could not before, and never suffers from headache, no visible discharge. H. D., R. 7, L. 6.

This patient still remains under treatment (July, 1893); her W. H. as well as voice hearing has gone up considerably; in every way she is better, but there remains an ulcerated condition of both ears, kept up doubtless by unhealed mastoid cells.

The comments I would make upon this case would be very similar to those upon the last one; both cases confirm the statement that the ear is very easily acted upon, and its diseases under the control of the simplest remedies possible, if given in single dose and at sufficient interval. The very simplicity of the whole matter with many minds will have a deterring influence.

CASE III.—A girl of twenty-one, an assistant teacher, admitted

29th of April, 1893, 12 or 13 years deaf from typhoid fever, getting rapidly worse. Both sides affected, the left worse. H. D., R. 15, L. 13. Gets a headache when tired across the upper forehead; used to have tinnitus, not now; hearing not best in a noise; digestion regular; membranes dry, anæmic; l. m. h. too prominent. Rx., *viola odorata*, φ A.

13th May, 1893. Very marked improvement. R. and L. 50 in. No medicine.

10th June, 1893. Very much improvement, sometimes has headache at night when tired; *viola odorata*, φ A.

1st July, 1893. In every way well, hearing splendidly.

I subjected this patient to close examination as to whether there could be any conceivable reason for her getting well, except the influence of the one dose given on the 29th April, and it was impossible to elicit any shadow of reason for the result, save the effect of the *viola odorata*.

It will be well to append some rough notes upon the action of *viola odorata*. A man forty-seven, deafness and perforation of both, *ta*, *viola odorata*, φ A.; two days after right ear discharged (had been quiescent for weeks); three days after there was much irritation and feeling of gathering in the ear (right) and a hissing, and an old feeling of pain like a glandular swelling under his tongue (*chorda ti. nerve*) returned for a short time; hearing improved. Six weeks before, *viola odorata*, φ A. was followed in two hours by pain in the stomach; returning for two or three mornings with a feeling of filling up and heat in the ear.

In a case of most rebellious otorrhœa, right side, in a man of 30, first dose of *viola odorata*, φ A. was followed by cessation of discharge for four days; the next dose, after three weeks, cessation for two or three days; after the third dose there was no discharge for eight days, and in every way he expressed himself as better than he had done during the two years he had been taking repeated doses of remedies.

In a case of left otorrhœa where the discharge had not appeared for several days, in a lad of 17, *viola odorata*, φ A. was followed by profuse discharge same afternoon from the ear.

Ear discharges profusely and general improvement sets in after *viola odorata*, φ A. in a child of 17 months, who had been affected with recurring otorrhœa from birth. Noises in both ears, with deafness, disappear.

A dull, heavy pain came in the left side towards the back in the

region of the lower ribs, not sharp or affected by breathing and lasted some days (spleen). Pains slight were felt in the ears and hearing for noises became clearer. (In an old case of deafness).

J. Collins, aged 50, deaf both, left discharging, on and off, seven or eight years, now for three weeks, but never so bad before. R. not, L. contact. In four days after *viola odorata*, φ A. there was a change for the better, and now hears. R. 8, L. c.

In girl 14; cold came on directly after taking dose, which lasted three days. In a woman aged 60, throat felt full and swollen on both sides as if the glands on the top of the throat were swollen for two days after the dose. In a boy of 14, felt very ill immediately after the dose; could not eat, and had very bad headache for two days with drowsiness; after this, improvement in the dormant ulceration of the ears, with deafness, set in. A man of 43, sometimes sharp shootings above the right ear to vertex and across to the left ear; hears best in a noise; sleep, heavy; six years deaf; improvement of all these.

A man of 30, deaf both, right, not; left c., slightly; right, three or four years; left ear swells, head giddy, hardly knows what he is doing at times, can't walk along a plank, very great pain at times in back of head, continually falling, especially if he stoops; staggers in walking, has had no benefit whatever from treatment in a special ear hospital; head felt better and clearer after *viola odorata*, φ A. than after any remedy I had previously given him during a treatment extending over twelve months, although he had in this time considerably improved.

CLOSURE OF WOUNDS IN LARGE VEINS.

BY WILLIAM B. VAN LENNEP, A.M., M.D., PHILADELPHIA.

THE following cases have been selected from my note-book as illustrative of the different methods of hæmostasis in wounds of the large veins, particularly those draining an extremity, or in the neck. The use of the gauze tamponade is purposely omitted as hardly applicable in these locations, although I have used it with gratifying results in wounds of the venous sinuses of the brain (lateral and longitudinal).

The first case I shall report rather fully as it presents other points

of interest. Reference will be made in the other cases to such features as seem worthy of mention.

I.—Rev. —, age 65. First noticed a growth on the left side of the neck in 1869, which apparently disappeared during the administration of iodide of potassium. It reappeared shortly afterward, and steadily grew until it attained a considerable size. In 1886 the diagnosis of bronchial cyst was made by a competent surgeon. It was tapped, about seven ounces of brown-colored fluid removed, and iodine tincture injected. This was repeated off and on for three years, when the cyst apparently closed, after an abscess developed and was drained. About a year later a large abscess formed in the remnants of the growth, and, when this was finally laid open, a fungating mass rapidly protruded from the incision. At about the same time the diagnosis of chronic Bright's was made.

In December, 1891, he came under the care of Dr. Middleton, of Camden, N. J., with whom I saw him. At that time the whole left side of the neck was swollen, indurated, and livid, and, from the opening in the tumor, there protruded a bleeding mass about as large as a fist. The urine contained granular and hyaline casts in abundance. The cyst cavity was cleaned out with the curette and packed, but in a few days, the gauze was pushed out by the rapid growth. This was repeated several times with similar results, and then the arsenic treatment, as recommended by Mitchell of Chicago, was given a thorough trial.

Microscopic examination of the fragments removed showed closely packed large cells, with here and there, an ill-defined acinar arrangement. This with a hard mass at the bottom caused a decided suspicion of malignancy. Several competent observers unhesitatingly declared the growth a carcinoma from the histological appearances, in which opinion I was inclined to concur.

As a last resort, and finding the growth somewhat movable, I determined to attempt extirpation. The tumor proved to be distinctly limited by a thick fibrous membrane, probably the capsule of the cyst. This was dissected out with great difficulty as it was firmly adherent everywhere, particularly to the pharynx, the hyoid bone, the larynx, and the internal jugular through three or four inches of its course. In separating it from the latter, the vein was opened in three places, one opening being at least half an inch long. These were closed with four artery clips which were brought out at one angle of the wound. The openings were closed by simply bringing their edges together, and the tips of the forceps probably did this

only in part. The circulation was readily seen to be going on through the vein. It was found that the skin could be drawn over the enormous cavity with moderate tension. The wound healed very kindly, the hæmostats coming away, after forty-eight hours, into the dressing which had been moved by the patient in his sleep. There was no further trouble or sign of recurrence until the patient's sudden death from apoplexy some fifteen months later.

The limiting membrane proved to be made up of firm, fibrous tissue. The fungating mass was probably papilloma, but if such a homologous growth could be termed carcinoma, on account of the histological appearances, this membrane separated it from the surrounding tissue. If the cyst was correctly diagnosed as branchial, the irritation with iodine was probably responsible for the growth of the lining epithelium, as well as the abscess formation.

II.—Mrs. —, age 40, operated at the Hahnemann Hospital. Recurring carcinoma of left breast in the cicatrix and cancerous axillary glands. In the two previous operations the growth and the mamma had been removed, and that sparingly. In cleaning out the axilla, a mass was found encircling the vessels, and in carefully teasing it off the axillary vein was badly torn longitudinally. The opening was drawn accurately together with two clips, which were left in place, and found loose in the dressing when it was changed at the end of a week.

The wound healed *per primam*, and there was no interference with the return circulation at any time. In fact, the patency of the vein was evident by inspection before the wound was closed. The operation was done over two years ago, and when last seen the patient had had no trouble with the arm, and there had been no recurrence.

I have since deliberately excised a portion of the wall of the vein in a similar case, in which the same treatment gave an equally satisfactory result. A wounded vein is not nearly so dangerous as leaving a portion of the growth behind, and thoroughness, scrupulous, and even daring, offers the only hope in these cases.

III.—Mr. —, age 30, operated at the Hahnemann Hospital. A very large lymphoma (?) of the right groin was removed, which dipped into the saphenous opening, and was intimately attached to the femoral vein. This vessel was opened longitudinally for over half an inch in dividing its attachments to the growth. The opening was closed by clamping the vein with a couple of hæmostats. It was my impression at the time that the lumen of the vein had

been encroached upon more than in other cases. The enormous wound was closely sutured and united without reaction, except at the opening through which the forceps emerged. Here there was some septic infection and suppuration, which was promptly controlled by active antiseptic measures.

At the end of ten days, after the wound was practically healed, the patient was allowed to sit up in a chair. There were no signs of obstructed return circulation. A day or two later, on exerting himself a little, he was suddenly taken with intense dyspnoea, agonizing pain in the left chest, followed by sharp pains in the right side of the head. The temperature rapidly rose to 105° , with small, flickering pulse and profound collapse. All these symptoms gradually subsided, and he made a complete recovery.

Probably the vein was more or less completely occluded and became thrombosed. The return circulation, as has been shown possible by experiments and clinical cases, went on through collateral channels. This is particularly apt to follow when a tumor of the groin has been present for some time. Infection may have so loosened the clot that a slight exertion detached it. Unfortunately, no microscopic examination was made of the growth, but the patient was reported well some months after returning home.

IV.—Miss —, æt. 16, operated at the Hahnemann Hospital. Cured tubercular ulceration of the chin and front of the neck, and then removed a chain of enlarged and softened glands extending from the jaw to the clavicle. As usual this was done with considerable difficulty on account of their intimate connection with the vessels and the inflammatory adhesions. In teasing out the last gland, one of the lowest, a rent was made in the internal jugular. The edges were held together with a hæmostat, and, being desirous of closing the wound tightly, so as to avoid deformity, I threw a ligature around the tip of the instrument (lateral ligature of the vein). While the dressing was being applied, the patient made attempts to vomit and profuse hæmorrhage took place. The wound was quickly opened and the blood turned out, but, the vomiting having ceased, there was no further bleeding. Fearing a recurrence I left the wound open and packed it with gauze, intending to do a secondary suture, but overlooked it. Healing took place kindly by granulation, without recurrence of the hæmorrhage. The patency of the vein lumen was easily demonstrated at the time the ligature was applied. This probably included but a part of the slit and held the edges of the remainder together when the vein was not overdistended.

About two years later (March, 1893), I removed a few more enlarged glands from the same and the opposite side of the neck, curetted a couple of ulcers on the chin, and took advantage of the opportunity to excise the depressed adherent cicatrix. Circulation was found to be going on in the vein. The wounds were closed with a buried or sub-cuticular continuous suture of the finest iron-dyed silk. The resulting scars are barely visible faint lines.

V.—Mr. —, æt. 28 years, patient of Dr. T. B. Bradley's. Dissected out a large lymphadenoma of obscure origin, in the right groin, firmly bound down by inflammatory adhesions, and beginning to suppurate in its central portion. The very varicose saphenous vein was torn half-way across where it dipped down to join the femoral. The edges were united by a very fine catgut suture.

The large raw surface was closed by sliding flaps from the abdomen and thigh, the edges united, without drainage, by a subcuticular, continuous suture of fine iron-dyed silk, after the cavity had been allowed to fill with blood.

A zigzag in the temperature, with redness of the skin, indicating sepsis, a condition readily understood when the character of the growth is considered, the wound was opened, the clot turned out, the cavity curetted and vigorously irrigated with bichloride solution, allowed to fill with blood, and again tightly closed without drainage. Under the influence of frequently changed, wet, sublimatized iodoform gauze, the wound healed without further reaction and without pus, leaving a minute linear cicatrix. The vein has not been heard from.

A word concerning the technique of vein suture. The smallest Hagedorn intestinal needle, threaded with the heaviest catgut it will carry, is used. By sewing with the catgut double, bleeding through the needle-punctures is prevented. Catgut is preferable to silk, as it swells, closing the puncture, and is quickly absorbed. The intima is accurately united by a continuous suture, which is brought back, drawing together the adventitia, and the initial and terminal ends tied.

The treatment of wounds of large veins has received some attention, and it certainly deserves consideration, especially when the vessel drains an extremity. Some have advised that in the case of the axillary, and particularly the femoral, the artery as well as the vein be tied. It is a question whether this should ever be done, even in the lower extremity. When the collateral circulation has been prepared by the gradually-increasing pressure of a tumor, it will often

compensate for ligature of the vein. The latter is unadvisable in any case, unless the vein be completely divided across. Longitudinal cuts, and even short transverse cuts, can be held together by forceps during the, at most, twenty-four hours necessary for the glueing together of the lining "serous" membrane. Even in extensive transverse wounds, a carefully-applied suture of catgut is preferable to occlusive ligation. The former takes considerable time, and presents, as I have found from experience, serious difficulties of technique; hence it seems to me that forcipressure should be substituted whenever feasible. In long openings several forceps may be needed, and in short ones, when it is desired to close the skin wound tightly, a catgut ligature can be thrown over the tip of the clip. Furthermore, as shown in the fourth case, and as I am convinced occurs when the forceps are used, the opening is not completely closed, but the edges are drawn against each other with sufficient force to prevent the escape of blood unless the vessel is over-distended.

It might be said that, in an incompletely-closed wound, there is danger of the entrance of air. This complication has been shown to be overestimated, and it seems unlikely that such an accident could occur when the edges are approximated, or immediately become so as the distension ceases. When the opening is first made it is, of course, advisable to occlude the proximal as well as the distal portion by pressure.

To sum up, it seems to me that in treating wounds of large veins we should

1. Avoid complete occlusion in applying the ligature or forceps.
2. Use forcipressure in longitudinal, or small, transverse wounds.
3. Close the opening with a catgut ligature in small wounds when complete primary union is desired.
4. Practice suture under favorable circumstances and in large wounds, particularly if transverse.
5. Ligate across only in the most exceptional cases, when the vein is completely or nearly divided, where the collateral circulation has been prepared, and never simultaneously ligate the corresponding artery.

LABIAL HERPES IN CEREBRO-SPINAL MENINGITIS.—Dr. F. Klemperer finds herpes labialis to be a quite certain differential diagnostic symptom of epidemic cerebro-spinal meningitis for it does not appear in the tuberculous form of the disease.—*Berliner Klinische Wochenschrift*, No. 29, 1893.

MEMBRANOUS ENTERITIS.

BY JULIA F. HAYWOOD, M.D., ROCHESTER, N. Y.

DR. PRITCHARD, in the July number of the *HAHNEMANNIAN*, speaks of this as a relatively rare disease. I think it is not so rare as frequently overlooked. In my practice of eight years I have had a number of cases, five of them recently under treatment. These five, coming under my notice since the beginning of the year, have varied much in the severity of the pain suffered, but the main symptoms were much alike. Pain, bloating, alternating constipation or diarrhoea, indigestion, sleeplessness, much tenderness, so that a slight jar was painful, and the passage of the characteristic membrane, made up the picture of all the cases. The pain has often been acute and severe, so that little respite from suffering was obtainable. One of the most severe cases has just terminated fatally from cancer of the stomach. She had previously been operated upon for cancer of the breast, and feared a return of the cancerous trouble. The membranous deposit with her has been extensive, one entire cast being expelled of eighteen inches in length. She improved very much for a time under *ars.* and *hydrastis*, locally by enemas and internally, but in the last few weeks intractable vomiting set in, and then the progress toward a fatal termination has been rapid, accompanied of course by great suffering.

Another, who has returned to her home at a distance, has all the accompaniments of tuberculosis, with hectic fever, emaciation, and diarrhoea. This last case has a family history of deaths from tuberculosis, and a sister at present is dying from consumption. I have not been able to note any improvement in her case except in the matter of nutrition and relief from much of the pain. Two of my recent cases are discharged as cured. One had little except iodide of mercury and flushing of the colon. She had had a diarrhoea of several years' standing, which had been pronounced incurable by several old-school physicians. She has remained two years in excellent health, where before, for several years, she had been an invalid. Another patient had an intestinal parasite, which seemingly was the cause of the membranous deposit. She was almost insane, but all these nervous symptoms ceased with the removal of the parasite, as did also the other abnormal conditions. *Kali bich.* cured another patient. The curable conditions are those apparently catar-

rhial in their nature, while those accompanied by the scrofulous, tubercular, or cancerous cachexia do not recover promptly, if at all. The one case under treatment had made a wonderful improvement under iodide of calcareum 2x. She is now, however, not so well, and stomach symptoms, suggestive of my recently fatal case, are presenting themselves. She is nearly 70 years of age, and the prognosis is doubtful.

Not much literature is available upon this curious pathological condition. Wood's old *Practice of Medicine* contains the fullest account, and Arndt says a little under "Chronic Enteritis." There is also an article in Keating's *Cyclopædia of Medicine*. I had an article upon this subject read before the last meeting of the Western New York Homœopathic Medical Society. Among the sixty or more physicians present, only two spoke of having treated or had such cases in their practice. I did not try arg. nit. on any of the patients treated. I used hydrastis, kali bich., hepar sulph., iod. of merc., iod. of cal., merc. cor., and other remedies which seemed homœopathic to the condition noted.

THE RATIONAL TREATMENT OF CERTAIN PUERPERAL DISORDERS.

BY GEORGE B. PECK, M.D., PROVIDENCE, R. I.

(Read before the World's Congress of Homœopathic Physicians and Surgeons, Chicago, June, 1893.)

It is related of an ambitious but pretentious lawyer that during his first argument before the Supreme Bench of the United States it became necessary for the Chief Justice to interrupt him with the suggestion that "This court may be presumed to know *something* about law!" The admonition of the eminent jurist is not unheeded. I assume that he who takes the time and the trouble to read or to listen to these words is tolerably familiar with the present teachings of the science of bacteriology, the present state of development of the germ theory.

Bacilli have been devoted attendants upon the human race lo, these unnumbered ages. We made their acquaintance but yesterday. Not too late, however, for they will continue to abide with us a few centuries longer. It is for us simply to determine upon a proper style of deportment toward our newly discovered companions.

The practical relations of human beings to such tiny yet murderous associates are susceptible of a threefold division, natural at once and logical. The underlying conditions are, *first*, the obnoxious microbes outside the unbroken covering, cuticular or mucous, of a vigorous healthy body; *second*, their actual storming of more or less accessible breaches in the vital armor occasioned by violence or by physiological processes; *third*, their establishment of camps within the human frame. Evidently, the functions of a physician toward these conditions are as diverse as the situations indicated, although in any given instance he may be compelled to discharge them all. Concerning the bearing of a surgeon toward disease germs, I will not presume to speak, although elsewhere I have intimated, by reference to unimpeachable authority, his subjection to the same principles which should govern his brother.

If a physician is consulted concerning pertinent matters when thoroughly satisfied none of these little creatures have discovered an entrance to his patron's body, he must act simply as a hygeist. To the performance of that duty, however, he should bring all attainable knowledge of the resources of sanitary science. This service has, singularly enough, been dubbed by some preventive medicine, an incongruous and absurd appellation.

Should a doctor succeed in catching any of the well-nigh omnipresent wanderers in an attempt to scale any breach opening to the citadel of life, he would at once thoroughly, though *gently*, sweep thence the invading hosts, for, as was shown in detail one year ago, experience and bacteriology alike forbid the application of corrosive or irritating substances to raw surfaces.

If aid has not been summoned until invasion has been measurably accomplished, the attendant's duty is still unmistakable. Since the chief physiological disturbances and anatomical changes (pathological conditions) subsequent to the lodgment of these impalpable foes within the human frame are the direct result, not of themselves nor yet of their work, but of the efforts of the organism to free itself from their presence, it follows as naturally and as inevitably as does the day the night that the *proper* course of action is the administration of medicaments which shall intensify and sustain (reinforce) the exertions of the affected organism in its endeavors to expel the intruders; in other words, the dispensation of remedies capable of producing corresponding phenomena when given to the healthy and sound. The possession of such property by any substance can be definitely known of course only through antecedent experiment.

Parenthetically, it may be remarked (*a*) that it is perfectly proper to speak of a person's being threatened with any one of many of the so-called diseases. Should an invading host be routed before it had deployed its columns, before it has clearly manifested its character, any assumption consistent with the apparent phenomena would be legitimate. (*b*) The inherent possibility of overwhelming the enemy at any time is also evident, although the synchronous destruction of his works is neither claimed nor expected. A reported cure at any stage of any case of an infectious disease requires, therefore, no stronger proof than other commonplace statements of alleged facts.

To resume: Since the laws of nature are general, not to say universal, originating not in human formulation but in the established constitution of things, and since the known field of infectious diseases is broadening with marvellous rapidity while extreme uncertainty attends the limitation of its boundaries, it is clear that with him lies the burden of proof who dares affirm that the administration to the sick of remedies capable of producing corresponding phenomena when given to the healthy is not the proper course of action in all curable cases.

Finally, since the character of the work of many microbes varies with the age, sex, and condition of their victim, and since autopsies frequently reveal their unsuspected presence at important points, there is no reason to expect a parasitic pathology will prove a more reliable guide in the healing art than have been the humoral, the methodic, and the pneumatic. Hence, naught remains for the true physician but to exemplify the singularly significant motto of this World's Congress, and day by day to treat,

"NOT THINGS BUT MEN."

DISTURBANCES OF THE STOMACH.

BY MILLIE J. CHAPMAN, M.D., PITTSBURGH, PA.

(Read before Allegheny County, Pa., Medical Society, July, 1893.)

THERE is a time when all organizations are at high tide of prosperity. Audiences are large and the willing workers are numerous. The machinery seems to move without motive power or effort to guide on the part of the managers. As certainly as cause precedes

effect and action is followed by reaction, there is another time when the personal interests of the members, either for profit or pleasure, draw them away from these same societies. It is a usual and common experience that a few whose devotion to the cause, or whose circumstances bring them to martyrdom, bear the burdens during the heated term. They maintain the organization until the return of comfortable seasons, when attendance is popular, convenient, and profitable. During this interim it is considered good business ability to secure speakers able to draw an audience and attract the attention of those assembled.

Hence, Mr. President, I appreciate highly the honor conferred by an appointment to read before you at this time, as well as the great responsibility connected therewith. To bring you here when you prefer to be elsewhere; to ask you to listen when you crave inattention; to offer instruction when you desire recreation, is so difficult a task that a greater mind would be more likely to meet failure than success. But merely to continue my record of at least making an attempt to do any and all work placed in my hands, I ask you briefly to review the influences which lead to disturbances of the stomach.

We have all had sufficient knowledge, either from personal experience, or by observing others, to know that dyspepsia, catarrh of the stomach and intestines, gastralgia, gastric ulcer, or cancer of the stomach, are undesirable conditions. I will not weary you by relating their symptoms or pathology, but rather consider how we may live to prevent the development of these forms of suffering.

First, man, woman, or child will suffer from an unhealthful stomach if its space is reduced. Whether it is the band of the infant or the fashionable clothing of adults that by pressure constrict the waist, the stomach is certainly injured. Instead of lines of beauty the process yields an injury deep and long lasting to the circulation. Next, the stomach is disturbed in the presence of impure air. The ingenious experiments of Claude Bernard and Charles Richet have shown us that the acidity of the gastric juice is produced chiefly at the surface of the stomach; that this acidity is due to the general action of oxygen, being the result of a veritable oxidation of the juices secreted by the gastric glands. These glands take from the capillary network with which the stomach is so richly provided, and which is always turgid at the moment of digestion, a quantity of oxygen, and this oxygen derived from the blood serves for the oxidation of the gastric juice. Then the oxygen is a direct influence

in rendering the gastric juice acid. Hence people who absorb by the lungs an atmosphere which is unwholesome and insufficiently oxygenated, experience all the evils which result from a poor quality of the gastric juice. They have all the symptoms which characterize putrid dyspepsia, viz.: Immediately after a meal the sensation of oppression, a load as of a foreign body in the stomach. Several hours after, when the aliments have passed the pylorus into the intestine, colicky pains are felt. During the entire period of stomach digestion the breath emits a fetid odor and eructations of sulphuretted hydrogen ensue. Pure outdoor air and baths which give cleanliness of body constitute the most powerful curative means. Hence the marked relief witnessed in many cases sent by the fresh air fund to the country. There, without pepsin or lavage or any medical care, they rapidly approach recovery. Others, apparently the same, remaining in unfavorable surroundings, the putrid state continues, fermentation increases, and gradually dilatation obtains. The victim becomes a regular attendant at the dispensary or free clinic. Much of the suffering we meet among children and their mothers, living in courts and alleys, depends upon this disturbance of the stomach produced by their environment. Thirdly, the stomach is disturbed by the quantity and character of the substances it receives. We are safe in saying that stones, skins, and strings are disturbing influences. Stones, such as cherry pits, seeds of grapes or raisins, and some berry seeds. Skins of grapes, apples, plums, figs, potatoes, etc. Strings, the fibres of celery, asparagus, strings of beans, and sometimes fibres in chipped beef. Any or all of these may do violent injury to the stomach, and, escaping there, almost certain to develop appendicitis. Liebig was the first to establish a scientific classification of foods, but the mixtures often taken could not be found on his list, nor the modified one of more recent writers, claiming they suggest all that is necessary to furnish nutrition or supply the incessant wastes of the economy. Stomachs, like the entire individual, vary in the ability to endure. The most sensitive being the first to suffer from errors in diet. There are many who cannot eat two acids at one meal and be well. Tomatoes and strawberries, or currants and rhubarb, or cherries and pickles combined in one meal, create much suffering, when only one will bring no discomfort, and benefit the system. Our lamented Hoffman advised that milk and meat be not eaten at one meal, and better not to use cream with berries, and, of course, not cream and rhubarb or preserves as so many persons frequently use.

The above errors are the common cause of acid dyspepsia, characterized by a feeling of oppression during digestion, the patient complaining of heat in the stomach, whereas in deficiency of gastric juice the stomach feels cold. The sensation of burning or heat increases; during the night there is regurgitation of acid matters into the throat and mouth, leaving a smarting impression along the œsophagus, known as pyrosis. A continued error of diet, in either kind or quantity, and we have the spasmodic pain about the cardiac region (cardialgia) or that severe pain felt in the dorsal region. The use of fried foods, fats, and sweet victuals are the origin of many catarrhal troubles. Such persons have continually a peculiar sour taste in the mouth. Later there ensues vomiting of glairy mucus; this may occur occasionally for a time, then becomes habitual, and is an every-morning affliction. Professor Dujardin-Beaumetz says of this condition: "First, the stomach is irritated by the substances eaten until it secretes too acid a gastric juice; then the pepsin-corpuscles cease to be reproduced, and the greater part of the glands are transformed into veritable mucus-glands, and no longer secrete real gastric juice but mucus instead." It has been written that man cannot live by bread alone, and many a one finds it difficult to live at all if he eats yeast-bread. The victim of gastritis or gastralgia suffers agony from this form when he may eat with benefit that known as salt-rising or some form of the baking-powder breads when cold. And some are better off by taking the hard pretzel, this requiring time and thorough mastication. In fact, few substances would irritate that stomach if taken with the Gladstonian bite. It is said the eminent statesman was taught in early childhood that all hard substances, and especially meat, should not be swallowed until bitten or chewed thirty-two times. No doubt this habit alone has added many years to his useful life. Susannah Wesley's method of raising her children on three meals a day and absolutely no eating between gave healthy stomachs to that large family circle. Her son, John Wesley, attributed to this cause his ability to do greater mental and brain work than his associates.

There are times when the stomach's greatest need is to receive nothing. An absolute rest would quiet soonest all irritation. Even in gastralgia, where the pain seems to subside by the introduction of food into the stomach, relief is often obtained by a large quantity of hot water. This distends the stomach and with the heat quiets the neurosis. Semmola says the causes of nervous dyspepsia are those which exhaust the nervous system in general, but princi-

pally care and mental worry, disappointment, and the violent emotions. With the nervous disturbances there may exist a true catarrh, but that is always secondary and arises from three influences: first, innervation affecting the capillary circulation of the stomach; second, the prolonged presence of aliments which digest slowly; and, third, the irritant action of all the products of a defective digestion. It is not always possible to banish care and mental worry. It is true that those who dwell on depressing influences are certain to suffer from gastric neuroses.

We are, to a large extent, what the cooks make us. Their skill is often represented by lack of skill, and in consequence we introduce to the stomach for digestion many deleterious substances. What we eat, when we eat, and how we eat have a large influence in building up health or disease of both body and character. He who would avoid suffering and live long can only do so by selecting food, in kind and quantity, that will not irritate that noble organ, the stomach. He who is reckless of his stomach is likely to be reckless in character. On the other hand, he who is careful of or controls his stomach is careful of and controls himself in all respects. I need not tell this audience that the unfortunates suffering from the above disturbances will find relief and often cure by favorable hygienic surroundings, correct diet and the wise selection of some of the following medicines: argent. nit., ars., nux vom., sul. acid, hepar., phos., puls., nat. mur., lyc., abies nig., kreos., sul.

OZONE FOR CHRONIC COUGHS.

BY F. P. WARNER, M.D., CANANDAIGUA, N. Y.

(Read at a meeting of the Western New York Medical Society.)

AND what is ozone?

Oxygen is a gaseous element, destitute of taste, color, and smell. This gaseous element when united with nitrogen produces air. Now when this air comes into certain conditions or becomes charged with electricity, so that you can taste it and smell it, then it (that is the oxygen) becomes ozone. Hence ozone from *ozein* to smell, is oxygen surcharged with electricity. We notice it sometimes after a thunder-shower. Its density is one and one-half times greater than oxygen. It exists in the atmosphere in a minute extent—a greater quantity

in the country districts than in the cities, while in crowded thoroughfares it ceases to be recognized. We can produce it by electrifying pure oxygen gas, whence it follows that it cannot be anything else than an allotropic modification of oxygen. But at the same time when we ozonize oxygen gas we condense it, and hence in its therapeutic effects it becomes a deodorizer as well as an intense oxidizer. Therefore its power to cure disease.

How can we produce it?

The speaker uses a gasometer, into which he puts two gallons of compound oxygen gas, then fills it with air, making a mixture of one part of oxygen and nine parts of air. Then this gas is forced into an ozonizing tube, which is connected with a powerful battery (a large coil and Grinnell cells) as it takes a powerful current to change the oxygen to ozone. Then the patient inhales directly from the ozonizing tube, thus filling the throat and lungs with ozone. This the patient inhales for about ten minutes daily. If this is too stimulating, which is indicated by dizziness, less of the compound oxygen can be used.

Now then as to ozone in therapeutics, or as to our subject, ozone for chronic coughs. In this subject we, of course, mean by *cough* an external symptom of an internal disease, and we would limit it to laryngitis, pharyngitis, bronchitis, and the early stages of phthisis, as in genuine consumption in its advanced stages our experience has been limited on account of the difficulty of such patients getting to the office regularly for the treatment.

In most of the diseases above named it is safe to assume that they occur in persons of an enfeebled constitution, and whose nutrition is below par, generally anæmic and assimilation poor. Hence any remedy which is to relieve them must be something which acts as a tonic, stimulant, and nourisher. All of this we claim ozone will do.

In the early history of oxygen treatment it was used only to relieve dyspnoea and cyanotic conditions following inflammatory condition of the chest, but fortunately now a better view is taken of the life-giving agent. We must recognize the fact that if we can with a limited lung capacity pass more or less continuously the same quantity of oxygen into the blood as is required in health, we practically lift our patient to the plane of health, or put him on the high road to recovery, and give him a tenfold better chance to battle with atmospheric influences of a depressing nature, and also increase his power of nourishment. Oxygen, pure air, is the great supporter and

retainer of life ; without it plants die, vegetation ceases ; without a sufficient quantity of it animal life becomes extinct, man dies. In other words, it is life. Disease means limitation of that life, and if not checked ultimately suspends activity. When, therefore, the natural forces, or that which sustains life are the curative agents, it is eminently proper to secure by every means in our power an abundant supply of that life-giving element throughout the whole system until the disease runs its course, or begins to yield to this power so necessary in our existence.

We say, then, that ozone is the most sure and satisfactory stimulant known. That by being passed through the lungs its entrance into the circulation is more certain and immediate than by remedies passed by the digestive tract. Prof. W. G. Thompson by his experiments upon animals with oxygen arrived at the conclusion that it would stimulate immediately a weak heart, and was pre-eminently the remedy for profound shock either from hæmorrhage or nervous drain when vitality is at too low an ebb to take up the intricate work of assimilation and repair.

In the treatment of pulmonary complaints the tendency at the present time is towards local medication. This we suppose comes from the theory of germ-disease, which teaches that tuberculosis originates from micro-organisms and from the fact that these organisms must be destroyed or rendered harmless to tissue or made to prevent such disease attacking the system.

On account of this germ-theory a more thorough study has been made, whereby antiseptics and germicides may be made to reach disease-germs in the lungs more directly and safely than heretofore.

If, then, tuberculosis and diseases of the respiratory tract depend upon the presence of micro-organisms in the system, then the most rational mode of treatment consists in the administration of antiseptics and germicides.

It is said that the most powerful antiseptic known is ozone, for in an atmosphere of it, it is impossible for germs to exist. As we said in the beginning, it is a deodorizer. Some claim it is the same as the peroxide of hydrogen. Its effect, therefore, upon the body is to increase the power of the system to purify itself, as the more oxygen and ozone is inhaled, the more carbonic gas is thrown off from the lungs—the more the blood is enriched. One thing the writer heard an old-school professor say once when lecturing upon iron ; never give iron unless you advise your patients to get out of doors a great deal so as to get all the oxygen possible ; and I have read many

testimonials from men eminent in the profession, that if iron refuses to do good when indicated, that ozone would awake the dormant powers and set the iron doing its intended work.

Many a cough comes nowadays from unused air-cells in the lungs, from an ignorance of the proper way to breathe, or from a constriction of the lungs from improper manner of dress. A lady at my office not long since when I directed her, while using the ozone inhaler, to draw long and deep inspirations, remarked that she could not. Asking for a reason she said her clothing was so tight she could'nt. This lady was possessed of a false pride. Thinking to be stylish and well dressed she must have her chest so girded that healthful inspirations were impossible; and yet she was suffering from a severe and persistent cough, partly nervous and partly from laryngitis. She is only a type of many foolish women. Now for these cases of unused lungs, what is more benefiting than to expand those air-cells by drawing into them a liberal amount of ozone or pure air, nature's own way of keeping the lungs healthful. Medicine will not compensate for ignorance in the proper way of breathing.

Ozone soothes the irritated and mucous membranes of the throat so that many a severe chronic laryngitis will be subdued and cough largely controlled. If it refuses to do so a mixture of oxygen and nitrogen monoxide two to one and then passed through the ozonizer rarely fails to accomplish its work.

In proof whereof of the foregoing statements, I will relate the following cases cured by the use of ozone:

CASE I.—*A Case of Bronchitis*.—Dr. P., an old-school practitioner, aged 72, had been suffering with la grippe and bronchitis for six weeks. He had been treating himself with all remedies known to himself, and was gradually failing. At this stage, being sent for, I found him very much emaciated; no appetite; some fever; heart's action weak; coughing beyond description; and expectorating freely a thick green mucus, accompanied by profuse perspiration.

Treating him for about a week with no apparent improvement, I suggested his using ozone. The doctor being anxious to get well and willing to do anything, I ordered an apparatus sent to his home, and from the first improvement began, and in a month's time he was out of doors and getting about, and made a complete recovery, and this done in the latter part of March and fore-part of April, the most trying season of the year, in a locality where lung and throat diseases are prevalent.

CASE II.—Mr. G., aged 55, was suffering from laryngitis and capillary bronchitis from la grippe. This case had all the symptoms of the above disease, and, like Case I., the cough was very violent and incessant night and day. All remedies of the homœopathic school, as close as the writer could prescribe, and some of the old-school remedies, also failed to relieve. The patient, after three weeks, was prevailed upon to come to my office (he being a farmer and living three miles from town) to use the ozone, and, like Case I., made a rapid recovery, though he was afraid the weather would kill him while coming to my office. This was also in March.

CASE III. is a case of chronic pleurisy, with adhesions and chronic laryngitis of several years' standing, in a lady of 43 years, with a tendency to phthisis, her first husband dying of the same. This case had night-sweats, poorly nourished, and violent coughing spells, with scanty expectoration. This case was relieved by the ozone for a long time, and the cough returning from catching cold again at the funeral of a man who died of phthisis (whether it was a cold or the germs from the house of the consumptive I know not), is being relieved again, and I think eventually will make a good recovery.

These are a few of many who have been restored by this powerful agent when remedies had seemed to fail.

For Anæmia, Ozonized Air.—Sufficient has been said to show the place and efficacy of this agent in the class of cases above mentioned. The reports by Prof. W. G. Thompson upon the treatment of cholera by ozonized air in the epidemic at Marseilles and Toulon are so flattering that, indeed, it would be well worthy a trial should that foul destroyer visit our shores during the coming summer.

The most marked results come, however, from those cases which might be called house-plants; the delicate, who, from necessity or otherwise, have been deprived of out-door life and exercise adapted to make robust health; people of sedentary habits, with sluggish circulation, small breathing capacity, and, in general, the broken constitution, whose vitality is so low that they become neurasthenic, or suffer from an internal malady whose external sign is *cough*.

LAPPA MAJOR IN PROLAPSUS UTERI.—Dr. Ockford relates a case of chronic prolapsus uteri cured by this drug in the third decimal dilution. A pessary had been worn for years, and in its absence, the uterus would protrude from the vulva. After a fortnight of *lappa*, it was removed and the uterus remained in position. The remedy was continued for several weeks, and a year after there had been no return of the trouble.—*North American Journal of Homœopathy*, March, 1893.

ORIFICAL SURGERY AND CHRONIC DISEASE.

BY S. G. GODSHALL, M.D., EDGE HILL, PA.

(Read before the Homœopathic Medical Society of the Twenty-third Ward, Philadelphia.)

SOME six or seven years ago Dr. E. H. Pratt, of Chicago, gave to the medical world his views on orificial philosophy which have since been so liberally besprinkled with criticism, scorn and ridicule.

The philosophy having lived and grown now presents itself, as a young giant, the indispensable agent in almost all chronic disease.

A few words as to this new philosophy.

We are to recall that all nutrition depends on the blood; given poor circulation, either general or local, and there is trouble; but with a good capillary flow all nature works in harmony. Now the blood supply depends on the condition of the vaso-motor nerves, the nerves which control the calibre of the vessels.

These nerves get their force from both the great nerve systems, the cerebro-spinal and the sympathetic, but it is the sympathetic on which they mainly depend, as the sympathetic never sleeps. We may be unconscious from normal slumber, from injury or from anæsthesia, and our sympathetic, like our guardian angel, watches over and keeps our heart pumping, our lungs contracting and expanding, and keeps going all the other necessary actions of life. Seeing the necessity of this nerve force we can readily see how a waste of it will affect the general nutrition and consequent health. In further elucidation of this philosophy we are reminded that we live by tubes, *i.e.*, our vegetative existence depends on tubes—our whole alimentary canal is one tube into which empty tubes from the liver, pancreas, etc. The salivary, gastric and intestinal juices are elaborated by tubes—our kidneys are a mass of tubes emptying into larger ones, the ureters, so to the bladder and urethra; and our bloodvessel system comes under the same category as do the bronchial tubes and their ramifications. All the tubes carry on their functions by peristalsis, and this peristaltic motion is controlled by the vaso-motor nerves; again we see the importance of conserving the force that supplies the vaso-motor nerves.

The next axiom dwelt upon is that "the irritation of an organ begins at its mouth." If this is not readily assented to recall that a cystitis begins as a urethritis, an endometritis as a cervicitis, a

vaginitis as a vulvitis, and who ever saw a chronic bowel disease without piles, pockets or papillæ?

As all muscles must be stimulated by nerves and get their power from nerve force, so any work of a muscle must have its consequent nerve expenditure. We know that when a muscle is called on to be continually contracted, it is much more wearing than when alternately contracted and relaxed; a man can walk about all day without excessive fatigue, but one hour's standing rigid will in many cases cause so much exhaustion as to thoroughly prostrate.

Remember that the openings of the body are controlled by muscles (sphincters) whose normal condition is neither contraction or relaxation. If anything causes these (one or more) muscles to continually contract we have the consequent exhaustion, the result of a waste of nerve force, and as a sequence other parts of the body are deprived of their needed nervous impulse. When these other parts become affected we call it reflex. The sympathetic nerves are both efferent and afferent, and if irritated they respond by muscular action. So irritation of the rectum will cause spasm of the sphincter muscle and continued irritation, such as may be caused by any abnormality, as piles, pockets, papillæ or polypi will cause continued contraction resulting in continued nerve waste.

Another fact Pratt has demonstrated is the intimate connection between the several orifices, their interdependence of normal function on one another. This he accounts for by saying that the nerve supply is by "pencils;" that the same nerve by different branches supplies different organs. The connection between the uterus and breasts is a familiar example of this branching; you all know how sucking the breasts will contract the uterus in childbed, causing afterpains. Dropping official philosophy we turn for a few minutes to chronic diseases. How do they differ from the ordinary diseases we have to treat?

Primarily by their chronicity, secondarily by their different manifestations, especially under treatment. How often have we treated a dyspepsia to a cure as we fondly hoped, only to find a varicose ulcer develop or a neuralgia manifest itself. I recall one case of eczema which turned to acute gastro-enteritis when suppressed, and later changed to a distressing asthma, with the peculiarity that when the asthma was less troublesome the eczema appeared, and vice versa.

This subject of chronic disease has puzzled the medical profession for ages. Hahnemann's theories of syphilis, sycosis and psora are in-

adequate, in my opinion, in many cases. Pratt says: "In all pathological conditions, surgical or medical, which linger persistently in spite of all efforts at removal, from the delicate derangements of brain substance that induce insanity and the various forms of neurasthenia, to the great variety of morbid changes repeatedly found in the coarser structures of the body, there will invariably be found more or less irritation of the rectum or the orifices of the sexual system or of both."

If this philosophy be true, what a veritable Eldorado it offers to suffering humanity; our prognoses must all be revised, diseases heretofore considered incurable may be made "to haul down their bloody flag of no surrender," and backaches, headaches, constipations, eczemas, dysmenorrhœas, asthmas, neuralgias, neurasthenias, hay fever, acne, hysteria, hypochondriasis, epilepsy, locomotor ataxia, palsy, insanity—and even consumption may no longer be the *odium medicum*—may all be as amenable to treatment as a pneumonia, a typhoid, or a scarlatina.

Heretofore, in a chronic case, we questioned and cross-questioned to get symptoms to fit a remedy, and unless some marked symptom pointed to orificial troubles, never bothered our patient with an examination; in fact, rarely thought of the rectum being a factor in the case at all. Now all is changed. When we find a patient who has been sick for some time, or who does not respond to medicine, our first duty will be to examine the lower openings and rectify any abnormality we find; and it will not do to ask our patients if they have rectal or sexual trouble, and rest satisfied if they say no. We must feel and see for ourselves. Just now I recall three cases to impress this fact:

No. 1.—A man of 40 years, who for eight years suffered from neurasthenia, was frequently unable to do any work; had had the homœopathic and "regular" treatment without success; when he heard of orificial philosophy he examined his own rectum as well as he could, and thought nothing was abnormal, but on my examining him I found a rectum full of papillæ and pockets, and he almost fainted on my introducing a rectal bivalve.

No. 2.—A manufacturer of Philadelphia, æt. 50, always ailing, now thinking he has consumption, now Bright's disease, now this now that,—you have all had such cases,—goes from one physician to another. I had had two trials at him without a particle of success, when he came again. I then asked if he had piles. "No," said he; "nothing the matter with my rectum." I insisted on an

examination, and found in the rectum hæmorrhoids of all shapes, colors, and sizes, and, of course, a contracted sphincter.

No. 3.—A woman of 55 years, several years past her climacteric, who suffers from intense daily headaches; she has been to the best prescribers of both schools without success. She said "her bowels were regular, caused no trouble," and she had not been "torn," although the mother of eleven children. An examination revealed extensive laceration of the perinæum, a cystocele, and a rectal sphincter so contracted 'twas impossible to introduce a bivalve without an anæsthetic.

In examining the male, see that the prepuce is not too long and is freely movable on the glans; examine the prostate, if too large, too small, or sensitive; the calibre of the urethra, the size of the meatus (it should be as large as the urethra); the frenum should be long enough to allow the penis to point directly straight when the prepuce is retracted.

In the female the hood should be free from adhesions to its clitoris. ("The clitoris is a little electric button which, pressed by adhesions, rings up the whole nervous system."—Dr. Morris in *American Journal of Obstetrics*.) The meatus urinarius should be smooth and the urethra freely dilatable; the hymen should not present rough, irritating edges; the vagina should be freely dilatable, and have no congested look; the labia minora should not be too redundant or hypersensitive. The uterus should be small, the cervix firm, and the os patulous. The rectum should be smooth, the rugia converging regularly to the anus from the buttocks; it should likewise be freely dilatable without pain, and the inner border of the sphincter muscle should be free from any roughness whatever.

It would lengthen my paper entirely too much to describe the several operations orificial philosophy has given birth to, and they are described very graphically in Pratt's book and also in the *Journal of Orificial Surgery*.

Before relating cases let me say a few words about the bivalve speculum. This is the instrument on whose merits orificialists claim it is no more dangerous to give chloroform or ether than to give a dose of morphia. It is with this an orificialist professes to resuscitate a partially drowned or smothered person, to relieve a case of shock, or make a newborn babe start up breathing if born asphyxiated.

CASE I.—A six weeks boy with eczema universale; had been

under regular care since birth, but the eczema developed at two weeks, and progressively got worse. I treated two weeks with sulph. 30 without other result than that the child did not cry so much. No change in the rash, one mass of sores and crusts. On examination found greatly redundant and tight prepuce. Circumcised, and in less than two weeks the baby was well. Have not seen it since.

CASE II.—Man of 26; had had gonorrhœa for over a year; had been treated by advertising specialists in Philadelphia, but although the discharge was only trifling, he felt bad all over. Nux vomica brought the discharge back as though in a fresh case, and cann. sat. cured the case with the exception of a drop or so of gleet in the morning. An examination disclosed a narrow meatus. I slit it up, and the gleet disappeared in a week, and now, six months later, has not returned.

CASE III.—A cretin of 3 years old. Cretinism began to develop at six months; never has walked or talked, shows no sign of intelligence; has a most remarkable macro-glossis, being unable to get the tongue entirely in the mouth; only four teeth; bowels always constipated, intense and long-continued straining only resulting in the passage of hard balls. He had an elongated prepuce and a contracted rectal sphincter. I circumcised him and dilated his anus. This being my first case of rectal work, I feared to go too far with the dilatation, and knew nothing of pockets and papillæ save that there were such things. The boy became somewhat brighter; for about six weeks his bowels moved regularly without straining; he cut eight teeth and attempted to walk, but always needed help; later he went back to his old condition, and on the 1st of June I again had him anæsthetized; found the anus as tight as before. I pretty thoroughly dilated it and removed five large pockets from the rectum. As yet (June 20th) I can see no benefit from the last operation.

CASE IV.—A girl of 8 years; mother died of phthisis; child has all her life had asthma in paroxysms, many of them so severe as to make her folks despair of her recovery; has latterly been getting worse and the attacks more frequent, some lasting two days and nights, during which she could not lie down, but had to be propped up in some one's arms. I treated her to the best of my ability for over two years with no success. On examining, found tied down clitoris; this I freed under an anæsthetic, and thoroughly dilated the rectal sphincters. The operation was on March 6th, since when she has not had a suspicion of asthma, but is altogether healthier than she ever was, and has gained decided flesh.

CASE V.—Boy, æt. 9, always has had headaches, two to three attacks a week, during which he had to go to bed. This boy is a runt in a family remarkable for large size. I had treated him several times during the last four years, as had another homœopath, and he also had been under the care of the best "regular" of the neighborhood, with no help from any of us.

I found a greatly redundant prepuce with a pin-hole opening.

Circumcised, snipped the frenum, which was short, enlarged the meatus, which was contracted, took 3 papillæ out of and dilated the rectum. He still has headaches, though not so often as once a week, and they are lighter than they were.

CASE VI.—Girl of 3 years, very changeable and with imperfect control of the urine; bowels always constipated. The clitoris was completely covered and bound tight with its hood; this I freed with the use of cocaine but could not get a chance to examine the anus. The mother did not keep the clitoris free, and it has healed, with some adhesions, though not quite so bad as before. For a couple of weeks she appeared no better, and developed a profuse leucorrhœa, for which and other symptoms I gave her sepia 30, and now her enuresis has left her, and she is as sweet a little girl as one ever sees.

CASE VII.—Boy of 5 years. This is the case I cited when mentioning the changeableness of chronic disease manifestations. He began with an eczema which would yield nothing to medicine, and which later developed into an asthma. Prepuce was very long, though loose enough to retract readily; some slight adhesions; broke the adhesions, amputated the redundancy, removed pockets and papillæ and dilated the rectum. The result has been encouraging. The boy still has some asthma, though, his parents say, trifling compared with before the operation. One peculiarity in this case is the difference in breathing while asleep. Before the operation, his breathing was so labored as to be audible all over a large room. Now, it is noiseless.

CASE VIII.—Married woman of 23 years, with dysmenorrhœa of eight years' standing, had been carefully treated with homœopathic medicine for three or four years without result; appears to have no abnormality of the clitoris, vulva, vagina, or uterus, but found a constricted anus. She would not allow an operation, so I got Pratt's rectal plugs, which she uses rather irregularly. Her May period was less painful than usual after the use of the plug a week or ten days, and her June period came without pain. The first she knew of it was feeling the presence of the flow; afterwards she experienced some distress, but nothing as compared with her usual suffering.

To recapitulate, I report:

One eczema, cured; one gleet, cured; two asthmas, one radical cure and one greatly benefited; one cretin, no result; one chronic headache, alleviated; one dysmenorrhœa, benefited; and one enuresis, cured with the help of medicine. The enuresis was the only case to receive medicinal treatment after the operation; the others were purposely left to the "*Vis Medicatrix Naturæ*," after the sources of irritation were removed, that the value of the orificial work might be properly tested.

In conclusion, Hahnemann has given us THE law of healing, *Similia Similibus Curantur*. Pratt has supplemented this with his dictum: "Perfect orifices give perfect health;" with these two divine

laws revealed to us, medicine is lifted from an art to a science. Another name will yet be added to make the trio. Whose shall it be? It will be the name of the discoverer of the mode of simplifying the selection of the similimum.

STERTOR AND ITS CONTROL BY THE LATERAL POSITION.

BY F. H. PRITCHARD, M.D., NORWALK, OHIO.

A FEW days ago, while standing near a building undergoing construction, I heard a terrific noise as if a heavy beam had fallen, and hurrying over, I found that a long piece of heavy cornice had fallen from the second story and precipitated with it the contractor in charge of the work, a man of fifty-four years. He was found to be unconscious and suffering from signs of grave inter-cerebral pressure: paresis of all the extremities, puffing respiration—buccal stertor, “le malade fume la pipe”—contracted pupils, cold sweat, collapse, a weak and thready pulse, etc. Hypodermics of brandy relieved the collapse and braced up his heart. His right eye was terribly ecchymotic, there was great chemosis of the corresponding conjunctiva, his left arm was found to be broken at the wrist—Colles’ fracture, and two wounds discovered on the right side of his head—one over his eye on the frontal bone, and the other on the right middle parietal region—with slight depression of the supra-orbital ridge. His nose had been injured, though not broken, and large quantities of blood flowed down his throat, threatening to choke him. This was partially relieved by turning his head to one side to allow it to escape from the nostrils, but yet a portion would run down into his trachea, and, with that which had already collected there, interfere with his breathing. I then thought of a procedure recommended by an English writer, and turned the patient upon his right side, and in a few minutes his breathing became quite natural and the stertor disappeared. The blood continued to escape at intervals from his nostrils. He was left in charge of another physician, as I was about to leave the city, and I heard that he never recovered consciousness, but died that same day a few hours after. This case presents several points of interest; on account of the numerous injuries, it being difficult to locate the point or points of possible location of fracture or fractures and consequent effusion or compression, and hence draw the outlines for a possible operative interference, though the supra-orbital wound showed a slight depression of the bone. There were two points of injury—the supra-orbi-

tal ridge and the parietal wound, with a possibility of basal fracture by contre coup. The feature to which I wish to call attention is the readiness with which his stertor was controlled by turning him on his side.

The English author mentioned was Robert L. Bowles, of Folkestone, England, who, in his little work, *On Stertor and Apoplexy and the Management of the Apoplectic State*, of which work he has kindly sent me a copy, clearly describes the various kinds of stertor and their management. Here he calls attention to the value of the lateral position. Stertor from various causes may be relieved by placing the patient in the lateral position. In cases of collection of fluids, blood, mucus or serum in the air-passages, placing the patient upon his side permits the fluid to gravitate to the lower lung and frees the trachea and the opposite lung. In apoplexy he claims that much of the congestion and dusiness of the patient's countenance is due to the dorsal position interfering with respiration and circulation and oxygenation of the blood. This same position also favors free inspiration in arrest of breathing from falling backwards of the base of the tongue, as in chloroform anæsthesia. I have not had any cases of apoplexy since I received this valuable little work, but I recommend my professional brethren to try this procedure in relieving the associated stertor of apoplexy, stertor from accumulated liquids in the air passages. Stertor he divides into nasal, buccal, palatine, pharyngeal, laryngeal and mucons. It is often a danger signal, and it indicates mechanical interference with respiration. In apoplexy the saliva and mucus run down into the throat and threaten to choke the patient. Much of the increased blood-pressure in apoplexy he claims to be due to this impeded respiration, and he cites Lauder Brunton (*British Medical Journal*, January, 1889) as stating that "nothing raises blood-pressure as much as suffocation." On page 50 he presents a case somewhat similar to mine: "I was called, in August, 1859, to a boy who had fallen on his head from a height. I found him lying on his back, snoring, senseless and collapsed; pulse irregular, and pupils alternating, contracting and dilating. The mouth was full of vomited matter. On turning him on his side the snoring ceased. He was sick several times with comparative ease. Presently he began snoring while on his side. His chin was bent on his sternum. On straightening his neck he was quiet. The boy slowly recovered. On three different occasions I have been summoned to cases of apoplexy with stertor, which were relieved by the lateral position, and in which the patients recovered—two with and one without paralysis."

EDITORIAL.

AND NOW — ?

AT length, after many days and many throes, the Commonwealth of Pennsylvania has and is possessed of a so-called Three-Board Medical Examiners' Act, which, in January of the coming year, by the appointment of the governor, will give her three Boards of Medical Examiners, and then — ?

From the one side come the heartiest congratulations; from the other the direst forebodings and most ominous predictions. To which are we to give ear? Are we to rejoice or to repent?

By the present act, and indeed by all the various acts establishing examining boards, one thing will be accomplished probably little thought of and less desired by the promoters of the movement, our graduates, after passing the Board, will be made legally the peers of the graduates of all other schools. The antiquated "box and book" taunt will be emasculated, and the public, being assured by the State that homœopathic physicians differ from others only in their method of cure, will quickly learn to judge of that method by the manner of its application and by its results. In this direction no more important step could have been taken to elevate homœopathy in the eyes of the public than the establishment of medical examining boards.

But that our victory—for as such the recent legislation must be regarded—will not necessarily be productive to our school of good only, must be acknowledged, and that it may even be the means of introducing discord and disunion in our ranks is rendered painfully evident by recent events in New York. It behooves us, therefore, carefully to decide the position that homœopathy is now called upon to maintain in view of the arguments advanced in order to obtain a three-board bill.

In the first place, we claim that the whole movement that has now, after many years, culminated in a just and liberal law, took its origin, not in an enlightened public or even professional sentiment, but in an illiberal trades-union spirit on the part of a minority of the profession, a sickening flavor of which trades-union spirit still clings to the whole measure in spite of the ennobling accessories. The first movement—the registration of the diploma and its possessor, or of the practitioner of ten years' standing without diploma—differed from the intolerance of the unions against the non-unions only in so far that the agitators were in this case able to gain the

sanction of the law. The love of liberty preventing many from endorsing this movement with the proper amount of enthusiasm, an additional emphasis was laid upon the beneficent side of the question, and the poor, dear public, and the dangers to which it, singly and collectively, was exposed at the hands of incompetent physicians, became the burden of her song. It became a sort of police measure. This, of course, brought over many more adherents, but there still remained some who believed that the public was amply able to care for itself in this matter, and that it really desired no protection, but only to be allowed to be killed or cured according to its own sweet fancy and caprice.

The final step was then taken, and "higher medical education" became the watchword. Now, of course, all were compelled to fall in line, for he must be a "bold bad man" indeed who would hesitate to advocate such a cause!

But if education needed elevating, the blame lay at the doors of the colleges. The professors, *therefore*, were not fit persons to judge of the competency of students; their examinations would be "inefficient and necessarily interested" (*N. A. J. of H.*, July, 1893), and *therefore* we must have examining boards so as to have "the fair and impartial supervision of the State" (*N. A. J. of H.*, July, 1893).

Although this logic is faulty, as any tyro can demonstrate, it has been made to appear conclusive, and any one who hesitates to endorse the necessity for examining boards is at once and thereby supposed "to put ignorance at a premium and knowledge at a discount." Homœopathy, that had always, and in the beginning of its history, with some degree of truth, been accused of laying undue stress upon a mechanical materia medica to the neglect of other branches of medical science, was compelled to endorse with seeming unanimity the movement, so as not to appear to antagonize the demand for higher education.

We know that the homœopathic profession neither was nor is unanimous on this point, and that many still hold to the opinion that the interests of higher medical education could be subserved by other quite different and equally as effective measures; but the false logic of circumstances has compelled us to withhold opposition.

The profession having been thus apparently unified, the trades-union spirit again cropped out in the proposed constitution of the boards.

Whether the suspicions and fears cherished by so many homœopaths as to the ulterior motives and intentions of the dominant school

in insisting upon its proposed single boards, were entirely justified or not, does not concern us now, we only know that the justice of our representations (shall we venture to say of our representatives?) with a very large admixture of special Providence, have given us a bill, the fairness of which to all parties cannot be disputed by any one who has that in view.

By its course in the struggle homœopathy in Pennsylvania stands committed :

1. To the advancement of medical education, and
2. To the principle that it is so separate and distinct a school of healing as to require entirely distinct examinations in therapeutics, practice of medicine and materia medica, but in these only.

The first point needs no comment; the constantly lengthening and broadening of her curriculum by our college proves her earnestness in this direction. The danger which threatens us in our present position is likely to result from a neglect to hold fast consistently to the second principle. The more extended and thorough the knowledge on *all* points of medical theory and practice possessed by the budding practitioner the better, and therefore in the colleges we would have the broadest, most scientific, and hence, most liberal medical education imparted that is possible in the time at command, preparatory to launching the now only diplomatized doctor upon a course of independent research. With the extent of this knowledge as such the Examining Boards have at present nothing to do; their purpose is to find out the fitness of the respective candidates to practice medicine according to their respective schools, for which it is true a certain amount of knowledge of fundamental branches common to all schools is deemed necessary. Our insistence upon three distinct boards has committed us to this view. Therefore if we would not stultify ourselves our examinations in the three branches, therapeutics, practice of medicine and materia medica, should be on *strict party* lines. Hence we cannot but applaud the action of the New York State Society and the Homœopathic State Board of Examiners in rejecting from the medical syllabus the line "physiological effects, uses and doses of drugs," as a subject upon which homœopathic students were to be examined. The plain meaning of the words enjoined a more or less detailed examination in the allopathic uses of drugs, and was therefore inconsistent with the three-board system, as well as unfair to the students. We trust that when our medical council determines the details of the examinations to be held it will keep this point in view. We regard it as of vital importance, and as a means of ultimately compelling the governments, municipal, State, and general,

to have regard solely to the general qualifications of a physician in their appointments. Then must be granted to each one liberty to practice medicine according to the dictates of his own conscience, because the question of method will be eliminated in the certificate of qualification equally in the cases of all. That it will react beneficially upon our school itself can hardly be doubted. Besides serving to bring out the fact more prominently that there is a distinct homœopathic method of practice, it will also tend to give coherence and life to the idea of the homœopathy of to-day.

Apropos of the subject of the colleges and college professors, we quote, without permission, from a letter of our good friend, Prof. Eulenspiegel:

“What mean these calumniators by their fault-finding with the professors? It is, at least, an inconsistent bird that fouls its own nest. If their teachers were so inefficient, what must they, their scholars, be? Is it not a case of what you Americans would call sore-head? I have known many professors here and in my own country (Germany). Abroad, they dispute and argue, but do not revile; but here—where is the dignity of the profession? I do not think all your professors are such inefficient, ambitious time-servers as many would have us believe. I have met some, even among the older ones, in whom I imagine I have discovered sparks of intelligence and culture which, under more favorable circumstances, might be fanned into something! In many, too, the fee-greed, which is assumed to be characteristic of the profession exclusively, has taken a queer shape, and has induced them to devote many hours in the busiest seasons of their professional life to lecturing and advancing the cause of Homœopathy, with nothing, or less than nothing, as a return. It is true, as compensation they wrote themselves *professors*; but since this distinction is shared with aëronauts, phrenologists, barbers and whitewashers, discount to that extent must be reckoned off.

“If, then, the colleges and teachers be so bad, why not reform them? What mean these Medical Examiners’ Bills? You do not appoint factory inspectors to examine the corpses of those that have fallen down the elevator shaft, but to see that railings are put around the openings to prevent persons from falling down and making corpses of themselves. So do in your colleges. Guard well the entrance and exit of your colleges, and you won’t need coroners.”...

So far the professor on this subject.

GLEANINGS.

GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D., AND FRANK H. PRITCHARD, M.D.

CAUSAL RELATION IN DISEASE.—David Drummond, in an interesting "Address on Medicine," delivered at the annual meeting of the British Medical Association, held at Newcastle-on-Tyne, August 2, 1893, treated of questions of ætiology—mainly in the domain of chronic diseases—which have a direct bearing upon diagnosis and treatment, condemning the prevalent tendency to multiply causes upon the slightest grounds. His specific theme was "unity in cause." In the class of more prominent morbid conditions, whose claim to belong to the category of diseases having a constant cause is pressing, he included the relation between *syphilis* and *locomotor ataxia*, which his experience teaches him to be constant; declaring that locomotor ataxia is invariably the result of antecedent syphilis; where the former is found there is an absolute certainty that there has been at a previous date the latter, to which this locomotor ataxia is in some manner due. Gowers, in his work on *Diseases of the Nervous System*, claims: "It is certain, however, that syphilis is not the only cause of the disease. In a few cases (less than 10 per cent. of the whole) it can be excluded with confidence." This point is disputed by Drummond, whose experience teaches him that "specific" disease underlies all cases of tabes; a view which is rapidly gaining ground in the profession. In view of the importance of the investigation, he does not consider it fair to wait until in 100 per cent. of cases locomotor ataxia can be unerringly traced to this cause. The inductive force of the 90 odd per cent. known to be due to syphilis is sufficient to convince all but the most caviling critic that syphilis is back of the entire 100 per cent.

General paralysis of the insane, is another disease which Dr. Drummond's experience compels him to ascribe to the same specific factor. The burden of proof in these cases is more difficult even than in the former, as nature, in robbing them of past-memories, has deprived them of the ability, if they possessed the will, to furnish true records; and again, amongst general paralytics there is a larger proportion of women than amongst tabetic cases—this fact lends an additional complication to the case. Notwithstanding these difficulties, Jacobson has recently declared that at least 65 per cent. of these cases are specific; and, years ago, Steenberg and others contended for the unal theory, namely, that there was "no general paralysis of the insane without syphilis." Here, again, Drummond applies the inductive method of reasoning, and claims that if we can trace 65 to 75 per cent. of the cases in face of all the surrounding difficulties, it is but fair to inductively admit the presence of syphilis in the entire 100 per cent. If further evidence is required, he cites the fact that this disease is virtually the only progressive mental disease with which we are familiar with a definite, recognizable anatomical lesion. While not predicting much therapeutical benefit from the recognition of the syphilitic cause, he claims it is impossible to say how many cases of locomotor ataxia and general paralysis have been prevented by the timely use of antisiphilitic remedies, when at the outset a clue of syphilis is forthcoming — *The Lancet*, August 5, 1893.

THE RELATION OF ANEURYSM TO SYPHILIS.—Dr. Drummond has, for many years, been deeply interested in the study of the connection between syphilis and aneurysm, and, in common with others, has been struck with the frequency with which the former occupied a prominent place in the history of sacculated aneurysm. In his experience (among iron-workers and miners) no indisputable case has come under his notice in which specific disease was wanting, excepting two or three examples of that interesting condition, acute softening of the arterial wall with aneurysmal bulging, in malignant endocarditis. In the past ten years, 145 cases of aneurysm of the thoracic aorta came under his notice in the wards of the Royal

Infirmity. He admits, that arterial strain through hard work is, of course, a factor in the production of aneurysm; but it is one that, in the vast majority of instances, requires to be multiplied by specific arteritis in order that the product be aneurysm, and then it is the lesser quantity of the two.

This view of Drummond's is in keeping, in fact, almost identical with that set forth by Dr. Welch, of Netley, in a paper read before the Royal Medical and Chirurgical Society, eighteen years ago. Both of these observers have had large experience of aneurysm—one with miners and iron-workers, and the latter in the army; and both reached the conclusion that mechanical strain, superadded to syphilitic lesion of the wall of the vessel, were the main causes of the condition, syphilis being the essential factor.—*Ibid.*

THE RELATION OF EMPYEMA TO PNEUMONIA.—The causal relation of empyema to pneumonia, one of the closest if not the most common, is, according to Dr. Drummond, another exemplification of the subject. He admits that there are cases of pus in the pleural cavity that have not arisen out of an attack of pleuro-pneumonia, due possibly to an acute septic pleurisy, or to tuberculous pneumothorax; or as the result of a simple effusion becoming contaminated by septic matter, as by means of a trochar, but these are exceptions. Excluding these, and it may be fairly concluded that empyema, the common disease with which practitioners are so familiar, may be ascribed to an antecedent pneumonia. It is of the greatest moment to recognize an empyema as early as possible, for the sooner pus is evacuated the shorter will be the surgical treatment of the case and the better the prospect of permanent recovery; and, further, if taken very early, a single tapping without incision and drainage may effect a cure. The doctor claims that the diagnosis of these cases turns largely upon the discovery of the pneumonic factor; in other words, familiarity with the fact that effusion following pneumonia is very apt to be purulent furnishes a clue to diagnosis.—*Ibid.*

THE RELATION OF CHOREA AND RHEUMATISM.—It is claimed that the divergency of opinion on this subject relates chiefly to the question of degree; nearly all allow a certain affinity between the two diseases. Dr. Drummond's cases greatly favor the idea of a singularly frequent and close connection between the two, and he is inclined to the view that, in a certain proportion at least, chorea is simply one manifestation of the disturbance by the rheumatic poison of the function of somewhat unstable and growing cortical cells; and if this conception be tenable in a few instances, it may be extended so as to include the whole of the familiar group of typical choreic cases so common amongst the children of nervous and rheumatic families and prone to yield to large doses of arsenic. He suggests that we may have, without joint mischief, a rheumatic diathesis to which belong the choreas, the pleurisies, the headaches, the cutaneous eruptions, etc., so frequently associated with rheumatism.—*Ibid.*

THE CAUSATION OF CARDIAC DISEASE.—Dr. Drummond claims that the study of cardiac lesions throws into relief the importance of tracing diseases to their true causes. They are all referable to primary conditions,—rheumatism, gout, specific fevers, tuberculosis, sepsis, alcoholic excess, syphilis, etc. Any of these conditions may be responsible for heart affections having more or less characteristic clinical and pathological features. The investigation of cardiac diseases should be based upon their antecedent and underlying morbid states; for the treatment and prognosis depend largely upon the particular agent at work. The same holds good with regard to other organs. The schools have attached too much value to the diagnosis of the particular valve lesion and too little to its cause. For example: we content ourselves with the shallow and often unimportant observation that this or that case is one of mitral regurgitation or double aortic disease, forgetful that what is of paramount importance is, not only the primary reason for the existence of the lesion, but also the cause upon which the symptoms belonging to any subsequent attack of cardiac failure may depend. The inquiry would necessarily embrace the questions, in the case of toxæmic lesions,—gouty, rheumatic, alcoholic, etc.,—is the poison still circulating? and what is the prospect of return?

An attack of *rheumatism* may damage a valve and leave behind a permanent legacy, but the structural change may be harmless so far as the health of the patient is concerned, so long as the real enemy—rheumatic poison—remains absent. An injured endocardium is very apt to suffer further damage under the influence of fresh rheumatic attacks, however slight; and it is these intercurrent rheumatic

accessions, often subtle and unattended by any outward manifestation beyond fever, that are fraught with great risk. So, also, is the case of *gouty* mischief; but here the causal factor is more constant and insidious in its operations, and its ravages are too often deeply rooted before they are recognized. This suggests the necessity of greater diligence in unearthing a latency so dangerous. In *syphilis* we have a much more common cause of heart disease than is usually admitted. That this is a morbid agent that might be met and treated if recognized at the outset; but how seldom has the attempt been made, though specific arterio-sclerosis is an obvious pathological entity. *Alcoholic* heart disease is now receiving attention, and fewer mistakes in prognosis will probably be made. Often the alcoholic heart fails suddenly; due to the fact that the mischief is more in the myocardium than the valves, and remains undetected. Careful attention to the ætiological circumstances will enable the physician to help the cardiac trouble in a more substantial way than if the defective machinery only is considered and treated. The doctor has demonstrated, in the post-mortem room, on more than one occasion, that the valve lesion from which the patient had suffered was due to a chronic tuberculosis of the pericardium resulting in general adhesions, and that the valves supposed to be diseased were in themselves healthy, though the orifices were dilated and the myocardium degenerated. Obviously the treatment and prognosis of such a case must differ from the treatment and prognosis of cardiac failure the result of old rheumatic pericardial adhesions, or of a heart damaged in early life by scarlatinal valvulitis and broken down by excessive work, or of a rheumatic case marked by returning and often protracted pyrexial attacks, or of an insufficiency directly due to alcohol.—*Ibid.*

THE MODIFYING INFLUENCE OF ONE DISEASE UPON ANOTHER.—Dr Drummond briefly considers some possibilities in the modifying or controlling influence exercised by one disease upon another. In this he is governed by the light of the principle of causation. Familiar clinical pictures of disease of an organ are often the product of the symptoms peculiar to it and of others which are the expression of impaired function of another organ. In other words, the full symptom-complex of disease of one organ may be largely contributed to by disease of another, whether produced by the same or some other cause. The controlling effect of disease on disease is to be seen in the fact that it is quite rare for pulmonary tuberculosis to spring up in the course of a cardiac affection; and, again, when lardaceous disease develops in consequence of a chronic phthisis, to observe a distinct tendency on the part of the tubercle to be arrested in its growth; and, further, in this connection may be cited the rareness with which a pneumonia complicated with jaundice proves fatal.—*Ibid.*

THOMSEN'S DISEASE.—This malady was first described in 1876 by the man whose name it bears, and who is also a victim of the disease. In the cases that have been studied he concludes that it is hereditary, and in his own family traces it back for five generations.

The disease is characterized by a peculiar stiffness of the muscles, which is suddenly ushered in by any effort at motion. The patient desires to make a movement, but is entirely unable to perform it until some time has elapsed, when, from the impulse of the will, movements will begin to be slowly evolved, and, after motion has commenced, it will become gradually easier until he has accomplished his purpose.

Microscopic examination of the muscle shows that the fibrillæ are broader than normal, the nuclei are increased, the perimysium greater in quantity; Bowman's sheaths are unusually close and give the appearance of vacuoles in the muscle.

The electrical reactions are changed. If the current is passed through the nerve trunk supplying the muscle, there is no alteration from normal; if the current is passed through the muscle itself, the contraction is easily produced, but when the stimulus is removed, the muscles do not cease to contract for a long time after.

The stiffness and immobility is particularly aggravated after a lengthened rest. In the morning, after a night's sleep, it is a long time before the patient can obtain the power of motion to leave his bed. Cold and hunger will also increase the stiffness, whereas heat, or after the patient has dined or enjoyed a little wine, voluntary motion is easily performed. As to treatment, we find that quietness and alcohol, with a highly elevated temperature, will add much comfort to the patient. Change of residence to a warmer climate is very advantageous.—*Medical Press*, July 26, 1893.

A STUDY OF A CASE OF FOCAL EPILEPSY.—The patient had convulsive seizures of the right arm, due to a sarcoma of the lower part of the left ascending parietal convolution. An oval area of the cortex, infiltrated with the growth, was excised. The piece taken away had the long axis antero-posterior and extending from the fissure of Rolando, in front, to just across the lower extremity of the inter-parietal sulcus behind. Sensibility to touch, heat and cold, and the appreciation of the addition of weights was unimpaired both before and after the operation.

Some observers have shown that excision of a large area of the motor part of the cortex is followed by loss of sensation on the opposite side; however, when a small area of the lower part of the ascending frontal convolution is excised, there is no discoverable loss of sensation in the paralyzed part.

It has been noticed in other cases that after the excision of a limited area of the motor region, there is paralysis of parts corresponding to the neighboring areas, and in this case, therefore, no surprise was occasioned by the fact that she had aphasia and paralysis of the face, tongue and leg after the operation, which did not pass off completely, probably due to the very rapid development of the other new growths which were found after death. She did not have any more convulsions after the operations nor any numbness. Her mental condition was good for thirty-two days, after which she sank and died on the thirty-eighth day after being operated.—*British Med. Jour.*, July 27, 1893.

A CASE OF RAYNAUD'S DISEASE.—This symmetrical form of gangrene is also known as "gangrene juvenile." If the disease should develop in winter time, it will be necessary to carefully differentiate it from chilblain, especially if ulcerated. In the case in question the disease began with a wasting and swelling of the legs as high as the knees. Her mother said that at night they would become livid, but in the day would be perfectly natural. One month later she was admitted to the hospital, the toes having become black and shrivelled. The child, who was four years and eight months old, had never walked—not on account of paralysis, but simply a weakness. On admission to the hospital the pulse was 144, regular and of high tension. The radial arteries were tortuous, thickened and easily felt. Pulsation could be felt in the dorsalis pedis artery of each foot and in both posterior tibial arteries. The patient immediately upon admission was ordered a generous diet, with half an ounce of brandy every twenty-four hours. In five days the line of demarcation had formed along the metatarso-pharyngeal joints, and a few days later the phalanges of the little toe of the left foot completely separated. About a month after admission the patient was chloroformed, and the remaining phalanges of both feet removed. An uninterrupted recovery was made, and a few months later was reported to be fat and well.—*Lancet*, July 29, 1893.

THE APPLICATION OF COLD IN PERICARDITIS.—The ice bag has been successfully employed in inflammations of various parts of the body, as in the neuritis of the sciatic nerve, perityphlitis, pneumonia, etc., and is now finding a sphere of usefulness in combating the inflammation of the pericardium. By experiment on frogs it has been demonstrated that cold is a powerful cardiac depressant; inflammation of the pericardium also acts as a depressant; but it does not necessarily follow that the application of ice over an inflamed pericardium will add to the cardiac depression. If it succeeds in checking the local inflammation, it may even lessen the depression and actually become a tonic to the heart. Which of these two results will follow can only be determined by the cautious employment of the ice bag and careful observation of the results.

In the subacute carditis of rheumatic origin in children, often attended with some friction sound and signs of cardiac dilatation, but with little pyrexia and few symptoms, each attack, however, leaving the heart more damaged than before, the ice bag is of doubtful benefit and is apt to depress; but the acute cases, even in children, derive great benefit from its use.

In many other cases in which the ice bag has been used, the patients have been known to ask for its reapplication, a fact that may be looked upon as a clear indication of the benefit which they were conscious of having received from it.—*Lancet*, July 22, 1893.

ABSOLUTE IMMOBILITY IN THE TREATMENT OF ACUTE PLEURISY WITH EFFUSION.—Dr. Volland, a Swiss physician, has, in four successive cases of acute pleurisy with effusion employed absolute immobility with success, basing his experiment upon the results which are attained from absolute rest in inflammation of the peri-

tonæum. The patients remained perfectly quiet for a long time, being fed with a spoon, passing their urine and feces into a flat bed pan which was slipped under them with the greatest care. Under no pretext does he allow them to turn in bed, but even abstains from performing auscultation or percussion. Under the influence of this treatment no remedies beyond a little morphine being occasionally used when the pain was too intense, the fever rapidly disappeared in all the cases. The greatest duration was eight days in a case of acute pleuritic effusion of tuberculous origin. At the end of eight days of absolute immobility there remained but little of the fluid in the cavity, which disappeared a few days later, and then only did he permit them to leave their bed.—*La Semaine Médicale*, No. 45, 1893.

THE PECULIAR ODOR OF EXPIRED AIR IN PHTHISICAL PATIENTS.—Prof. Rosenbach, of Breslau, calls attention to a peculiar odor observed in the expired air of phthisical patients which resembles the odor of slight cases of putrid bronchitis, but differing from the latter in that it is of an insipid, sweetish odor. It is volatile, and is not associated with the sputa, and it is best observed when the patients cough or they respire deeply with an open mouth. This symptom is of value, prognostically, for these cases have a gloomy outlook. It is not found to accompany pronounced destructive processes, and it is most pronounced when the physical signs are but slight. It nearly always accompanies disseminated broncho-pneumonic induration of the lung. In infiltration of whole lobes or in foci which give rise to great dulness and in cavities the odor is not observed. In very profuse expectoration it is also absent. In a strikingly large number of patients in which this symptom was noticed pulmonary hæmorrhages appeared, there were profuse night sweats, anorexia, irregular febrile movements, etc. It is probably due to decomposition from micro-organisms in the lungs and diagnostically this factor is of importance, for it indicates the early presence of abnormal processes. Hence in cases with such breath he recommends one to look for pulmonary disease. It may possibly be due to insufficient care of the teeth, when a tooth wash will soon clear up the case.—*Wiener Medizinische Presse*, No. 28, 1893.

ACUTE NEPHRITIS AFTER VACCINATION.—Dr. Perl relates an interesting observation which shows that the already long list of acute infections nephritides of infancy and childhood as scarlatinous, diphtheritic, morbillous, parotidic and varicellic nephritis is not entirely exhausted, and still another must be added, namely, vaccinal nephritis. The patient was a child of thirty-three months, which had presented slight symptoms of rickets and some eczema around the anus. Three days after having been vaccinated with animal lymph by three inoculations upon each arm was suddenly seized while the pustules had begun to develop, with pains in the region of the kidneys and abdominal colic. The urine was scanty, thick and of a dark-red color containing 5 per cent. albumin, blood corpuscles in large number, some leucocytes and tube casts. No fever. Under the influence of absolute rest in bed and milk diet the urine became normal at the end of six days. The pustules did not present anything abnormal in three other children inoculated with the same lymph, nor was any abnormal renal symptom to be observed. The writer thinks that vaccinal nephritis is more frequent than is supposed, for, with its slight symptoms, it might easily pass unobserved.—*Berliner Klinische Wochenschrift*, July 10, 1893.

ŒSOPHAGEAL DIVERTICULA.—Dr. C. Dugge describes a case and then gives a review of our knowledge of the subject. The symptoms are characteristic: the food regurgitates, the patients are able to swallow better in some positions of the body than others, and there is great fætidity of the breath from decomposition of the food particles in the diverticule. In many cases one may feel a tumor behind and near the trachea, on one side, which, under certain circumstances, may be evacuated by pressure, and again be caused to fill by having the patient drink water. On examination by the sound, resistance was met with immediately under the cricoid cartilage, which did not feel like a stricture that could be overcome by increased force nor a smaller sound. By a certain position of the sound a smooth passage could be gained into the stomach. It is differentiated from carcinoma, in that carcinoma generally appears at the lower or lowest portion of the œsophagus, and in case that it begins higher up, glandular swelling and extension into the interior of the larynx soon occurs. In carcinoma the tip of the sound is often covered with blood on withdrawal. The prognosis is unfavorable, especially when the emaciation is great. Operative interference is the only rational treatment, though in one case the patient

irrigated his diverticule twice a week and thus kept himself in fairly good condition ; in another, feeding with the sound brought about a successful result.—*Muenchener Medicinische Wochenschrift*, No. 28, 1893.

GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D.

TREATMENT OF FRACTURE OF THE FEMUR IN THE NEW-BORN.—Ellefsen, in fractures of the femur in the new-born, applies a splint covered with flannel to the anterior and posterior surfaces of the femur, and over this a layer of cotton and a circular bandage. Then the limb is fixed, in extreme flexion, on the abdomen of the child and secured there by a few turns of the same bandage. Fracture of this bone, in very young infants is associated with difficulties that are overcome with great difficulty on account of the dressings becoming soiled or wet through. They require to be frequently changed, and the process of healing is thus interfered with. In this manner if the few turns become soiled they are easily changed without disturbing the fracture. In his case the bandage was removed on the fifteenth day and healing found to have taken place without shortening or disfiguration. The forced flexion and fixation to the abdomen did not seem to trouble the infant, which was perfectly well and happy during the entire treatment.—*Norsk Magazin for Laegeridenskaben*.

TREATMENT OF TUBERCULOSIS OF THE JOINTS BY A SOLUTION OF IODOFORM IN GLYCERINE.—Nauman (Helsingborg, Finland), has treated twenty-nine cases of articular tuberculosis by means of a mixture of equal parts of alcohol and glycerine to which 10 per cent. iodoform is added. After puncture the joint is irrigated with a 3 per cent. solution of boric acid whenever possible. The quantity of iodoformized glycerine varied from 5 to 10 grammes ($1\frac{1}{4}$ to $2\frac{1}{2}$ ʒ). In nine cases the disease affected the hip-joint; four of these were cured. Eleven involved the knee, of which four were successfully treated. Four others implicating the tibio-tarsal articulation were followed by a cure. Among these was a man of seventy years. Finally, five cases of tuberculosis of the elbow gave three cures. These patients were under observation for a period varying from one to thirty months. Fifteen patients cured gives a percentage of 51 ; nine ameliorated, 30 per cent. It is probable that a portion of these latter recovered completely later. After the injections he advises massage.—*La Semaine Medicale*.

TREATMENT OF PURULENT PLEURISY.—Debove and Courtois-Suffit (Paris) state puncture to be of service in urgent cases as in children and in cases of chronic empyema where an operation offers no hope. Repeated puncture is but palliative. Bacteriological features determine whether irrigation should follow operation. Some empyemas may be absorbed, and others, especially metapneumonic, expectorated; yet too long waiting is not to be advised, for an acute empyema should not become chronic. In general, they recommend the following: empyema from pneumococci requires pleurotomy or puncture and no irrigation. Recovery follows rapidly. Streptococcic infection demands rapid and thorough evacuation. Irrigate and repeat according to the pus, temperature and strength of the patient. Staphylococcic pus requires the same treatment. In gangrenous forms a good sized opening and antiseptic irrigation—sublimite or chloride of zinc. In the tuberculous varieties conservative measures are recommended: Puncture with injection. Formation of a fistula is to be avoided on account of the loss of fluids. Estlander's operation is not indicated here.—*Centralblatt für Chirurgie*.

INTRACRANIAL COMPLICATIONS OF PURULENT INFLAMMATION OF THE MIDDLE EAR.—Rissler (Stockholm) states the reliable symptoms to be headache, vertigo, vomiting, constipation, alterations in the optic nerve and retina, septic fever, general depression, cerebral torpor, profuse discharge of pus from the ear, œdema in the auricular region. In case of suddenly developing high fever complicated with otitis media, with violent headache, severe vomiting and delirium which soon pass into depression and coma, it is very probable that the disease has extended to the

cerebral membranes, producing acute purulent leptomeningitis. In sinus thrombosis there are chills and irregular fever, with great variations of temperature, metastatic abscesses, chiefly in the lungs, with continuous and dry cough. The external jugular is sometimes collapsed and empty, œdema of the soft parts of the neck, hoarseness and dysphagia. There are two stages of cerebral abscess: the premonitory and manifest stages. Premonitory: headache, vomiting, vertigo, epileptiform attacks, as well as psychic disturbances of more or less severity. The symptoms are paroxysmal with free intervals. An uncomplicated abscess may not be accompanied by fever. Reduction of frequency of the pulse-rate, a progressive hemiplegia, disturbances of speech, characterize the second stage. A trial trepanation with such symptoms is indicated.—*Hygeia*.

LAPARATOMY IN PERITONEAL TUBERCULOSIS IN CHILDREN.—Conitzer (Hamburg) has operated on seven cases of peritoneal tuberculosis in children, varying in age from two to nine years—two boys and five girls. The disease appears in two forms: an exudative and a dry form. Four of the cases were of the exudative—diffuse peritonitis with slight adhesions, numerous tubercles and free ascites, but slight disturbance of the general condition. Physically, only simple ascites was to be found, once associated with pleuritis. In one case the stools were gray and clay-colored, with fat in the feces. The dry form was observed in three cases. The peritonæum here was densely thickened with many adhesions—no ascites. Prognostically the latter is the less favorable form. The diagnosis is to be made by palpation when abnormal bands and indurations are felt. As to immediate operation, the exudative variety may heal spontaneously, the dry never. If internal medication fail, operative interference should be undertaken. Puncture is but palliative.—*Muenchener Medizinische Wochenschrift*.

THIERSCH'S METHOD IN LUPUS.—Heidenhain (Greifswald) has treated several cases of lupus of the face with success by Thiersch's method of skin transplantation. In this district, Pommerania, the disease appears very frequently in its severe forms. The results with the thermo-cantery and curette were not lasting. Transplantation is now employed wherever the disease may be situated or however extensive it may be. The affected spot is extirpated and covered with strips from the thigh. The first case was a girl with ulceration of the entire cheek from ear to mouth. In a few weeks she left the clinic, cured by two operations. A year after she returned with a recurrence which was also extirpated and covered with strips of new skin. Since then several other cases have been operated, and though still under treatment they show that one may hope, in a case of lupus of the entire face to replace the affected skin by integument from the thigh.—*Muenchener Medizinische Wochenschrift*.

ICHTHYOL IN ANAL FISSURES.—Van Der Willigen (Rotterdam) recommends ichthyol in the treatment of anal fissures. He introduces a small camel's-hair brush into the anus, filled with pure ichthyol; by contraction with the sphincter it is pressed out of the brush and all the folds of the mucous membrane are reached. This is applied once daily, and at the same time fluid food is ordered, with now and then a dose of castor oil to keep the stools as soft as possible. In one case, where all other methods of treatment had been tried in vain, ichthyol brought about a cure in eight days; a second case was cured in ten days; a third, which had been operated on unsuccessfully, healed in fourteen days, and a fourth in three weeks. In no case did he observe a recurrence. This treatment is not painful and has no disadvantages; only in one case did an eczema appear, which soon healed.—*Wiener Medizinische Presse*.

AUSCULTED PERCUSSION OF THE LONG BONES TO DETECT A FRACTURE.—Vajana describes a method of detecting a fracture of the long bones. A stethoscope is placed upon the bone and percussion done either by the examiner or a second person, when, in case of a fracture, a loud and harsh sound is heard, which is diminished by withdrawing the stethoscope from the point of fracture. It is to be explained by the solution of molecular continuity which interferes with the transmission of the sound. The difference is still better observed by percussing the opposite bone and comparing the results.—*La Riforma Medica*.

THE TREATMENT OF GRANULATING WOUNDS.—Van Arsdale (New York) writes of the attention paid to the healing of wounds *per primam intentionem*, of the

frequency that this gratifying result obtains, but devotes most of his article to the treatment of wounds which must, of necessity, heal by second intention. He decries the present methods (very much the same as those applied to primarily aseptic wounds) used in treating granulating surfaces and cavities, and speaks of the complications and disadvantages attending the use of *dry* dressings upon sensitive, delicate granulations, for which, also, drainage must be supplied. The chemical antiseptic substances used in these dressings irritate the wounds and make them appear inflamed; so much so, that almost all wounds which we see in these antiseptic days are actually irritated wounds.

For the past eight or ten years the writer has made use of oily dressings, and lauds highly balsam of Peru dissolved in castor oil. This combination remains for any length of time in contact with the wound, but does not (if properly applied), prevent the absorbent gauze dressings from taking up blood or secretions from the wound, and does not, therefore, interfere with drainage. The oily solution saturates the fibres of the gauze, while the aqueous fluids are drawn into the interstices. The wound, therefore, is moistened by the oil and balsam, and at the same time drained of its aqueous moisture.

A 5 per cent. solution of the balsam of Peru in castor oil is spread upon five or six layers of gauze, which are placed upon the wound, then a protective layer of rubber tissue or oiled paper is applied, and the whole bandaged. The dressings need not be changed often—twice a week generally sufficing on the average.—*New York Medical Journal*.

PNEUMOTOMY FOR PUTRID BRONCHITIS AND CAVITY OF THE UPPER LOBE OF THE LEFT LUNG.—Hofmohl (Vienna) reports the case of a man, æt. 25, who had suffered from bronchitis for four years. The expectoration was very profuse and fetid. Physical examination of the lungs revealed dulness, diminished breathing, and subcrepitant râles.

Owing to the patient's wretched condition, and the inefficacy of medical treatment, an operation was undertaken, having for its object the opening of a suspected cavity with the Paquelin cautery. An attempt was made to accomplish this without resection of the ribs, and for this purpose an incision ten centimetres in length was made in the second left intercostal space. The lung, which was adherent to the pleura, had a grayish appearance, and on palpation had the consistence of liver-tissue. An attempt was made to reach the cavity by pushing a grooved sound through the lung-tissue, and enlarging it with a Paquelin, but it was not possible to reach the cavity in this manner. The wound was tamponed and the patient returned to bed, with the hope that the cavity might burst into one of the canals formed by the sound. As this hope was not realized, a second operation was performed.

The cutaneous incision was enlarged, and the left third rib resected, beginning two centimetres from the sternal margin. Punctures were made in different directions with a sharp-pointed Paquelin. At the fourth attempt the cavity was reached, and was followed by the escape of air and fetid sputa. While endeavoring to enlarge the canal with dressing forceps, a profuse hæmorrhage occurred. By immediately tamponing the wound with iodoform gauze, and the hypodermic administration of ergot, the hæmorrhage was arrested, and the patient experienced no bad effects. The sputa gradually became less and less, and the slight fever that had been present disappeared rapidly. The patient entirely recovered.—*Centralblatt für Chirurgie*.

SEVERE INJURIES OF THE EXTREMITIES.—Reclus, in severe injuries of the extremities from railroad accidents, machinery, etc., would not do immediate amputation or exarticulation, as the shock is only thereby increased, and it is next to impossible to determine the living from the dead tissues. He proceeds conservatively: wrap the patient in warm clothes, inject subcutaneously caffein, ether or artificial serum, cleanse the injured member, and irrigate every corner and crevice with hot water which is hæmostatic, disinfectant and warming. Then pack all portions of the wound with a weak iodoform gauze or one filled with a salve of either boric acid, antipyrin, salol or iodoform, and wrap the limb in cotton. In the course of four weeks the necrotic tissue will have separated and the bone merely remains to be severed if amputation be required. The soft parts will heal quickly as they are then granulating. He employed this method successfully in two cases: a crushed foot, a leg and knee, respectively.—*Gazette des Hopitaux*.

GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D. AND J. NICHOLAS MITCHELL, M.D.

DEVELOPMENT OF THE PLACENTA IN TUBAL GESTATION.—After a microscopical study of numerous specimens of tubal gestation, Dr. Charles Dixon Jones gave the following summary of the conclusions arrived at:

1. In the earliest stages of the formation of the decidua the folds of the tubal mucosa become enlarged, their connective tissue returns to protoplasm, their blood-vessels become considerably dilated and engorged with blood.

2. Upon the approach of the decidua, the columnar ciliated epithelia of the tubal mucosa enter upon a process of proliferation resulting in the production of embryonal or medullary corpuscles.

3. The medullary corpuscles are developed from previous columnar epithelia, and in turn transformed to decidual tissue. Although epithelium is considered by most histologists a tissue unable to produce other than epithelial tissue, I can positively maintain the transformation of tubal epithelia into the myxomatous connective tissue of the decidua.

4. The delicate fibrous connective tissue of the tubal mucosa is reduced to protoplasm, the stage of indifference from which decidual tissue originates.

5. The smooth muscle fibres of the mucosa proliferate produce medullary corpuscles much the same as columnar epithelia, and ultimately disappear by being transformed into decidual tissue.

6. In the third month of tubal pregnancy a lively new formation of placental villi takes place, first by a thickening, afterwards by a budding out of the epithelial layer of the older villi.

7. These buds are protoplasm in nature, and are identical in their structure with that of the epithelial layer which gave origin to them. At first the buds are non-nucleated; later on they become supplied with nuclei.

8. The originally solid buds become differentiated into a peripheral epithelial layer and a central connective-tissue layer. The latter is at first made up of medullary or embryonal tissue, and afterwards becomes transformed into myxomatous tissue.

9. The capillary bloodvessels grow into the central tissue by a sprouting of the older capillary loops. The sprouts are originally solid, and in turn become hollowed out by vacuolation, thus connecting with the older bloodvessels.

10. Since I have demonstrated that the epithelia of the tubal mucosa are transformed into decidual tissue and that the new villi of the growing placenta originate by budding of the epithelia of the older villi, I have furnished strong presumptive proofs of the views announced by Rabl, that all tissues of the body are originally epithelial in nature.—*The American Journal of Obstetrics*, 1893.

LIGATION OF THE BROAD LIGAMENTS.—MARTIN.—The two patients upon whom this operation was performed were prepared as for a vaginal hysterectomy. They were put upon a laparotomy diet for two days before the operation, and the bowels were thoroughly washed out with enemata. Besides the ordinary general bath and the antiseptic bath on the morning of the operation, the external genitals and the vagina were thoroughly cleansed with soap and water, shaved and rendered aseptic by douching, etc. The patient was anesthetized and placed in the exaggerated lithotomy position, as for vaginal hysterectomy, with an assistant on either side to support the limbs and hold the retractors. A broad, short vaginal retractor, above and below, exposed the cervix, which was transfixed with a strong silk ligature to be employed in handling the uterus. Before tying this ligature a piece of gauze was packed into the cervix to absorb any secretion from the uterus, and the ligature tied so as to retain it. The uterus was then drawn down in order to put the broad ligaments on the stretch, and then drawn to the right side so as to expose the left vaginal vault. The mucous membrane of the vagina at the utero-vaginal fold on the left side was then caught with a tenaculum and incised with a pair of curved scissors. One blade was then allowed to enter, and a curved incision one and a half

to two inches long was made over the broad ligament and at right angles to it. By means of the index fingers of two hands the vaginal tissue was separated from the broad ligament, and carefully separated the broad ligament in front from the bladder for a height of two inches, and laterally for nearly the same distance, using two fingers for the purpose. By freeing the bladder in this way the danger of wounding that organ was avoided, and by pushing the separation laterally the ureter was pushed out of reach. Then the broad ligament was carefully separated posteriorly to the same height as in front without penetrating the peritonæum. Then, by passing one finger behind, the other in front, the whole base of the broad ligament, representing two-thirds of its width, was grasped for a distance of an inch to an inch and a half from the uterus. In this grasp could easily be felt the throb of the main trunk of the uterine artery and several branches. Then a curved needle, armed with No. 12 braided silk was passed, guided by the index finger of the left hand, behind the broad ligament, well up beyond all pulsating vessels. Next, with the same index finger guiding the point of the instrument, the broad ligament was penetrated through. The ligature was drawn through, the needle removed, and the base of the broad ligament firmly tied at a distance of one inch or more away from the uterus. The ligature was cut short, leaving it well buried in the tissues of the ligament. The opposite side was treated in the same manner, the vagina was well irrigated with bichloride solution, and then the vaginal incisions were accurately approximated with fine catgut, completely burying the silk. The handling string in the cervix was removed and the vagina packed with iodoform gauze. The after-treatment was very simple. It consisted in removing the gauze on the third or fourth day, followed by antiseptic douches. The vaginal wounds were perfectly healed at the end of a week.—*American Journal of Obstetrics*, April, 1893.

SYMPHYSEOTOMY.—Symphyseotomy is destined to displace the relative section Cæsarea. It may save the child in cases made unfit for Cæsarean section through prolonged labor and manifold instrumental interference, as experience has repeatedly shown that Cæsarean section is but seldom successful in these cases. But it can never take the place of the sectio Cæsarea under the absolute indication, that is, in cases of extreme pelvic contraction. It has been shown that the increase of the conjugata vera amounts to about 1.5 centimetres. Therefore the operation should not be performed if the conjugata vera is below 6.5 centimetres. Morsani places the lowest limit at 6.7 centimetres, and, as he has performed the greatest number of operations, it seems prudent to rely on his experience.

The conditions necessary to the performance of a successful symphyseotomy are the following :

1. The woman must be free from infection.
2. The pelvis must not be ankylosed or have an extreme oblique contraction.
3. The foetal heart sounds must be good.

The technique of the operation is described in the following words :

1. Emptying of the bladder, thorough disinfection of the abdominal wall and the external and internal genitals.
2. The operator stands between the extended legs, which are supported by one assistant on either side. These assistants place one hand under the knee and with the other make counter pressure against the sides of the pelvis.
3. Incision down to the symphysis.
4. Division of the muscularis pyramidalis and detachment from the symphysis of the prevesical tissues.
5. The index finger is placed behind the joint, which is then divided with a curved, probed-pointed bistoury from above and behind to below forward. In looking for the symphysis it should be remembered that its situation in the median line is the exception. The ligamentum arcuatum should, if possible, not be divided.
6. The foetal head is pressed into the pelvis and delivery accomplished. While the head passes through the pelvis the leg should be extended and the assistants must make counter pressure against the trochanters.
7. Arrest of hæmorrhage.
8. Suturing of the wound by three or four strong silk ligatures. The sutures should be passed through the skin and include the anterior surface of the symphysis.

9. The pelvis is immobilized by a strong canvas belt buckled in front.—*The American Journal of Obstetrics*, May, 1893.

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

CHLOROFORM ANÆSTHESIA AS AN AID IN THE DIAGNOSIS OF LARYNGEAL OBSTRUCTION.—In cases of laryngeal dyspnoea, where there is doubt as to whether the dyspnoea is due to mechanical obstruction or to spasm, it is a simple matter to give a child enough chloroform to relieve the spasm, if it exists; in cases of simple croup, this procedure is sufficient to relieve the symptoms of obstruction, and to satisfy one that no mechanical obstruction exists—at least not enough to demand operative interference.

Dr. Betz reports the case of a child, æt. eighteen months, that presented the typical symptom of laryngeal croup. The case appeared so hopeless that tracheotomy was, although proposed, rejected. Three drops of a mixture of ether sulph. 3 parts, acetic ether 1 part, menthol 0.1 part, were ordered to be inhaled every quarter of an hour, just as chloroform is inhaled. It was hoped that the cold from the evaporating mixture would contract the surface bloodvessels of the larynx, and thus reduce the œdema present. The child was seen again in two hours, and the condition had somewhat improved. The etherization to be continued, three to four drops every half hour. After six hours, the condition was unmistakably better—so much so, in fact, that the etherization could be dispensed with. A piece of intestine filled with ice was placed around the child's neck. After this, progress was so rapid that in twenty-four hours the child was out of danger.—*Archives of Gynecology*.

DISEASES OF THE PNEUMATIC SINUSES OF THE NOSE, AND THEIR RELATION TO CERTAIN AFFECTIONS OF THE EYE.—Under this title Dr. George W. Caldwell, of New York, states that it is an established fact that certain forms of conjunctivitis, lachrymation, palpebral irritation, blepharospasm, etc., may be relieved by judicious treatment of the nose; and conversely, that too extensive and unscientific destruction of the intra-nasal tissues may produce a like condition. He advocates conservatism in nasal surgery and states that every irregularity does not need to be smoothed down, that the artistic effect is not important.

Cell diseases are probably more common than recognized even by specialists, because of the difficulty surrounding their diagnostication. Some patients have a morning headache until the changing positions of the head allow the sinuses to drain through the nose or throat. The pain of ethmoid disease is referred to the eye or orbit, and is accompanied by injection of the conjunctivæ and sometimes by marked circulatory disturbance, such as ciliary congestion, hyperæmia of the disk, and even, as reported by Eales, of Birmingham, of optic neuritis. In his case there was no orbital cellulitis, and no symptoms to attract attention to the nose until the sudden escape of a large quantity of pus, when the neuritis at once subsided. Lennox Brown has reported a case of glaucoma cured, after iridectomy had been made, without improvement, by removal of nasal polypi.

Infra-orbital neuralgia points to disease of the antrum, while supra-orbital neuralgia is more especially connected with ethmoid disease, and would indicate that the ethmoid cells are affected. The pain is frequently referred to the eye, and is frequently worse in the morning.

His conclusions are, that the diseases of the pneumatic sinuses of the nose, and especially of the ethmoid and sphenoid, are much more important ætiological factors in the causation of ocular diseases than has been generally recognized; the ethmoid diseases being more especially manifested in intra-ocular and conjunctival circulatory disturbances, and in the production of a group of symptoms which may be called asthenopic; while the diseases of the sphenoidal cells are more likely to affect the optic nerve by the extension of a slow, conservative dural inflammation either in a functional or inflammatory way; and that the motor nerves may in a like manner, be affected.—*Medical Record*, April 8, 1893.

COCAINE PHENATE.—Dr. Townsend says the advantages of the cocaine phenate solution may be summarized as follows: 1. Obviates toxic effect. 2. Augments anæsthetic effect. 3. Renders aseptic the solution and the field of operation. 4. Diminishes inflammatory reaction. 5. Prevents chemical systemic poisoning, and renders improbable the cocaine habit.—*Journal of Ophthalmology, Otology and Laryngology*.

MONTHLY RETROSPECT OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D., AND FRANK H. PRITCHARD, M.D.

THLAPSI BURSA PASTORIS IN METRORRHAGIA.—This remedy acts upon the muscular coats of the bloodvessels, causing contractions throughout the entire system; it does not act upon the muscular fibres of the uterus. By contracting the bloodvessels, it causes a reduction in size of an enlarged and hyperplastic uterus, thus reducing the size of the abdomen and relieving the bearing-down sensations.—*The Homœopathic Journal of Obstetrics*, May, 1893.

IODINE IN PNEUMONIA.—Iodine is a very valuable remedy in pneumonia, and followed by most satisfactory results. It is indicated by a severe chill, followed by hoarseness; dry, short cough; tightness across the chest; dark-gray expectoration, soon followed by piercing pains through one side; a rapid rise of temperature, and the expectoration becoming blood-streaked.—*New England Medical Gazette*, July, 1893.

DIET IN PNEUMONIA.—The following rules may be laid down in feeding pneumonia patients: 1. Give no solid food. 2. Let the food be simple and nutritive. 3. Give food at frequent intervals and in small quantities. 4. Let the patient have all the pure cold water and cooling drinks he may desire. 5. Solid food, given during convalescence, will often cause a relapse.—*New England Medical Gazette*, July, 1893.

SEPIA.—This remedy belongs to the ganglionic or vegetative group, and hence is deep and long acting, producing profound results on the nutrition. It causes an atonic condition, one of lassitude, of muscular weakness and relaxation not only of the voluntary muscles, but also the involuntary, including those of the bloodvessels.

Some of the most important characteristics of the drug are: 1. The gone feeling in the epigastrium, due to the determination of the bowels to the lower abdomen. 2. The feeling as though the womb would drop out, causing her to sit down and cross her limbs for support; this is due to relaxation of the uterine supports as well as to a passive hyperæmia of the organ increasing its weight. 3. The prolapsus recti and feeling as though there was a weight in the rectum, described by some provers as a "round ball." The same atonic tissues give the sepia patient the characteristic "pot belly." Accompanying the above symptoms we have a sensory hyperæsthesia, characterized by mental irritability, an intolerance of odors, strong light, and noise indicating the drug in gastric and uterine disorders and sick headache; also an intolerance of contact often indicating it in pruritus.

The sepia patient, oftener a female, is delicate, dyspeptic, and depressed, the latter both as to mind and viscera. Typically, she is both beautiful and graceful, but abnormally sensitive, and the slightest emotion in her will produce circulatory ebullitions; in short, she is so delicately poised that her harmony is easily destroyed. Her complexion is sallow, but becomes red when excited or disturbed. The congestions involve the portal and genito-urinary systems; hence, the hot flushes begin below the belt.—*Southern Journal of Homœopathy*, July, 1893.

ONOSMODIUM VIRGINIANUM.—We have in *onosmodium* a remedy with some peculiarities and occupying a sphere unique, a curative range differing from that of every other drug.

Among the most prominent symptoms indicating its use are the following: In the mental sphere, drowsiness of mind and confusion of thought; dulness of intellect; a dazed feeling; complete listlessness and apathy; cannot concentrate the thoughts; great irritability of temper; continuous dull headache; pains in the left side of the head and over the left eye, extending around the left side to the back of the head and neck, aggravated by moving or jarring; dull, heavy pain in the occiput, pressing upward with a dizzy sensation; the eyes are heavy and dull; the lids are heavy; there is a dull, heavy, sore pain in the eyeballs.

In the digestive sphere, there is morning sickness, like that of pregnancy; craving for ice-water and cold drinks, wants to drink often; the abdomen feels bloated and distended, which is relieved by undressing; a constant feeling as though diarrhoea would come on; the stools are yellow, mushy, or greenish-yellow, stringy, with tenesmus.

In the sexual sphere, it is indicated in the stage of full development of sexual debility. In the initial stage, *picric acid* is indicated by sexual erethism. In onosmodium, we find in the male that the sexual desire is diminished; nocturnal emissions; deficient erections. In the female, we find severe uterine pains, with bearing down; pains passing from one ovary to the other, aggravated by pressure; sexual desire is completely destroyed.

In generalities we find great muscular weakness or prostration and tired feeling over the entire body. The least exertion produces a tremulousness. The muscles feel treacherous and unsteady as though one did not dare to trust them. All sensations worse in the left side.

The aggravations are generally from motion or jarring, from pressure or tightness of clothing.

The ameliorations are peculiar and marked. Better when quiet, when lying on the back, when undressed, when in the open air, from sleep, from cold drinks, from eating.—*Homœopathic Physician*, July, 1893.

CHININUM ARSENICOSUM IN PHTHISIS.—This remedy has been very useful in phthisis when the symptoms are markedly intermittent. The symptoms indicating its use are: anxiety, restlessness when alone, fear of death, irritability of mind and body, pain in eyes and black spots after reading, pale face, cough dry and hard, night sweats, loss of appetite, hectic flush, exacerbation of symptoms at regular intervals.—*Pacific Coast Journal of Homœopathy*, July, 1893.

DULCAMARA.—This drug is especially suitable to phlegmatic, torpid, scrofulous, psoric, weakened constitutions and individuals, with restless, irritable, angry disposition. It is especially indicated in pains which increase in proportion as the affected part is kept quiet; it is likewise indicated when the skin is liable to catch cold, especially in the joints, arms and feet, therefore in all affections which originate in a sudden cold, owing to damp and cold air or water, also in metastases of rheumatism or cutaneous affections.

In its action on the mucous membranes we find in dry or fluid coryza that it is indicated by obstructed nostrils, profuse discharge of water from the eyes and nose, sneezing, worse during rest and in the open air, better during motion and in a closed room. In diarrhoeas it is seldom indicated except in cases traceable to taking cold or to a change in the weather from warm to cold. The stools are watery or mucous, with aggravation at night, preceded by cutting pains in the abdomen, which continue during the evacuation and are accompanied by thirst, nausea and vomiting, with relief of pain after stool, followed by weakness and great prostration.

The rheumatic cases calling for dulcamara are acute when produced by its usual cause—cold or following acute eruptions. When due to the latter cause, glandular enlargements are apt to accompany. The pains are of a bruised, paralytic nature, also drawing, sticking or tearing, better from motion, worse when at rest.—*Ibid.*

PICRIC ACID IN ALBUMINURIA.—The disease followed childbirth, and was characterized by the following symptoms: dull pain in one or both eyes on awakening in the morning, pain increases in severity and extends through the whole head and down the nape of the neck, lasting all day. Pain when severe is pulsative in character and worse by exertion of either mind or body, even by turning the eyes. Pain passes off during the night and the patient sleeps well. Under the exhibition of picric acid, the headache and the albumin in the urine disappeared.—*North American Journal of Homœopathy*, August, 1893.

PHOSPHORUS IN BRAIN-FAG AND SUBACUTE PHARYNGITIS.—Great mental irritability, fault-finding, easily exasperated, restless. Feeling as though a cloud rested on the brain. The fauces are deep red and dry. Uvula deep red and swollen. Throat irritable, voice hoarse and tires easily. Lateral pharyngeal walls hang in folds.—*Ibid.*

LILIUM TIGRINUM IN FEMALE DISORDERS.—Headache from left supra-orbital region to left temple, to vertex and occiput; worse before menses. Nervous and irritable; quarrelsome disposition. Uterus displaced forward, cervix and vaginal mucous membrane slightly congested. Pain in left ovary. Bearing down in uterine region. Sexual intercourse painful. Frequent desire to urinate, with burning. Urine contains mucus. Constipation. At times a yellowish leucorrhœa.—*Ibid.*

RHUS TOX. IN HÆMOPHILIA.—Yellow skin, with itching. White stools. Stitches between the scapulæ when swallowing, so that he eats and drinks very little. Urine contains clotted blood, also fresh blood as from a cut. In the case reported the boy had swelling about the left knee of a doughy character. He would bleed to death from a slight cut unless pressure were applied.—*Ibid.*

THUJA OCC. IN VERTIGO.—The vertigo was worse while walking or after riding in the cars, also on closing the eyes, but better when reopening them. Better when lying down. Dull pain in the occiput with the vertigo. Nervous and apprehensive when about to transact business.—*Ibid.*

KALMIA IN CARDIAC HEADACHE.—Dr. Proll relates a case of a boy of thirteen, who suffered from headache and weak memory to such an extent that he was obliged to leave school. The cause was found in an insufficiency of the cardiac valves, and *kalmia* 1 was given three times a day. In three days there was slight improvement. The remedy was then given twice daily in the second dilution with a marked amelioration. The third dilution was now substituted and continued for seven days, when the headache had wholly disappeared. Seven months after the boy was found to have been studying without interruption.—*Hom. Monatsblatter*, No. 1, 1893.

ÆNANTHA CROCATI IN EPILEPSY.—Among his patients in Middletown Asylum, Dr. Talcott has many chronic epileptics. He has tried several homœopathic remedies on these in the past, but has obtained no definite amelioration save with *silicea*, which has done real good in cases where the attacks recur not oftener than once a week, and are apt to be especially severe about once a month. Since using *ænantha* however—which he has done on a large scale—he has noted much more decided results. The attacks have become much less frequent, and less violent, and the mental state before and after these, and in the intervals between them, has been notably improved. The drug was given in the mother tincture, one to six drops a day.—*Report of the Middletown Asylum*, January, 1893.

RATANIA IN PRURITUS ANI.—Dr. A. M. Cushing, taking some heavy doses of the tincture of this plant to stop an obstinate mucous diarrhœa (which it did), found it caused severe itching of the rectum. He has since used it with rarely failing effect when thread-worms caused this trouble. *Sanguinaria nitr.* also, he finds beneficial in itching and burning of the rectum unconnected with ascarides.—*Med. Century*, March, 1893.

THERAPEUTICS OF WOUNDS—Arnica.—Muscular bruising, soreness, ecchymosis. Use it hot, internally and externally; apply layer after layer.

Ledum.—In stone bruises, punctured wounds, nail, pitchfork, bee sting; internally and externally.

Calendula—A torn wound with loss of substance, ragged, lacerated skin or muscle; internally and externally. Promotes granulation and prevents suppuration.

Hypericum.—If nerves of spinal column have been injured. Will prevent lockjaw.

Staphisagria.—For clean cut wounds, surgical operations, etc.

Ruta.—Injury to periosteum of carpal or tarsal joints, caries of bones.

Symphytum.—When bone itself is injured, fracturing; internally and externally.

Silicea.—Splinter remaining in parts; promotes suppuration and drives it out; felons.

Cicuta.—Consequences of swallowing sharp pieces of bone; remove that of course; but the danger of spasm of the glottis.

Conium.—Injury to glands, mammary glands and testicles. Its main field is in the mammary glands, and in hysterical girls from reading loose literature or from over-thinking on sexual matters, without being able to satisfy their desires.—*American Homœopathist*, August, 1893.

SEPIA IN A FACIAL ERUPTION.—The eruption was chiefly on the forehead and chin, and consisted of papules, red and irritable; sometimes they would become pustules, but more frequently became scaly. The eruption was aggravated when hot; first thing in the morning; on coming indoors from the open air; at times of the menstrual periods.

The eruption was first noticed when the patient was in Spain, after partaking of boiled cuttle fish.

A careful study of the case and the symptoms pointed to *sepia* as the remedy, which proved curative, for under its administration the papules, pustules, and scalliness disappeared, and the skin of the face resumed a healthy appearance.—*Homœopathic World*, August, 1893.

NITRIC ACID IN CHOLERA.—Experiments on guinea-pigs, rabbits, and dogs show that poisoning with nitric acid takes the same course and shows the same symptoms as inoculated cholera in these animals. An involuntary proving in a patient of Dr. John H. Clarke, which was repeated a number of times, gives us the following symptoms: "Severe pain in the stomach of the cramp sort; rather violent sickness and shuddering cold and moderate diarrhœa of the spasmodic sort, which afforded no relief; also a heavy headache and great thirst."—*Ibid.*

TARANTULA IN DIPHTHERIA.—The onset of the disease is sudden and violent; there is intense febrile excitement; as a rule the patient is thirsty, sometimes for small drinks often, and sometimes for large drinks often; anorexia; sometimes vomiting; usually they complain of soreness of the throat and painful deglutition: occasionally they do not complain at first of any soreness of the throat, and have no difficulty in swallowing; as a rule, both sides of the throat are uniformly affected.—*Pacific Coast Journal of Homœopathy*, August, 1893.

CROTON TIGLIUM.—From the pathogenesis of this remedy we find that it has an intense and wide action on mucous membrane, causing both irritation and inflammation. Some characteristic symptoms beyond those generally recognized, will be found in the following, and will serve as "key-notes" for its use. Burning, pricking, smarting pains in the eyes and eyelids, the nasal passages, the mouth, throat, and œsophagus, generally accompanied with slight swelling of the mucous membrane and with vesicular eruption, photophobia, supra-orbital neuralgia, pustular eruption on face, enlargement of the tonsils, constriction of the throat, making deglutition difficult and painful. On the mucous membrane of the stomach, there is a similar action, and here is very useful in gastritis, attended with sinking sensation and tenderness in the epigastrium, desire for food, which causes an aggravation of the pain when taken, no relief being obtained until the food is passed downward or is vomited; in such cases the tongue is generally dry, red, and sensitive. In the intestinal tract it has a similar action, and has been very serviceable in abdominal colic, with a sensation of emptiness, coldness, borborygmus, and a spasmodic, watery diarrhœa.—*Homœopathic Review*, August, 1893.

CHELIDONIUM FOR NIGHT TERRORS.—A girl, five years old, had, at times, a peculiar foetid odor of the breath, which was always followed by an attack of screaming at night, while apparently awake, but she could not be aroused for some minutes; seemed to be very much frightened; would cry easily the next day; urine very yellow, and stained deeply. There is no record of sleep symptoms under *chelid.*, but in Hering we find, yellow or red urine, and in Eggert, under "urine staining the linen yellow," *chelid.* is given in heavy type. A number of remedies have screaming at night on waking from sleep, but, what had the urine to do with that? The symptom was peculiar to the case and the characteristic of the drug, the two necessary conditions pointed out by Hahnemann. *Chelid.* was given, with the result that the stools became more free, and had the same odor that the breath had (symptoms moving from above downward, the curative direction), and that there

were no more paroxysms for three months; the *chclid.* was repeated, because no new symptoms had arisen, but it did not help (although a different potency was used), probably, because the peculiar urine did not return. *Ignatia*, the prescription being based on the mental condition, helped at once. The child is of a light complexion, sallow, excitable, and nervous, and is not yet entirely free from slight manifestations of irritability, at which times she seems to be beside herself, and cries easily and violently over trifles. She had little or no trouble after this attack.—*North Am. Journal of Homœopathy*, August, 1893.

GUAIACUM FOR A COLD.—Mrs. A., about sixty-eight years old, took cold in a street-car from suppression of perspiration. She had a stuffy feeling in her chest, cough which seemed to come from the centre of the sternum and caused a rasping feeling in throat and chest. Lee and Clarke's *Repertory*, on Coughs, gives *guaiacum* as the only remedy having "stuffed sensation in chest causes dry cough;" although rasping in throat and chest is not mentioned under that drug, it helped promptly, and the cold disappeared rapidly.—*Ibid.*

ARSENICUM IOD. IN SUPPURATION.—Boy, æt. 2 years, showing so-called scrofulous tendency, was operated upon for phimosis. Two days after the operation the wound began to inflame, and a discharge of ichorous pus followed. The medicine was given every hour, the first dose at 8 o'clock in the evening. It was continued regularly throughout the night. The next morning the discharge was bland. *Ars. iod.* was continued once in three hours. The discharge finally stopped and the wound healed, but the glans penis was scarred and contracted.—*Ibid.*

IODINE IN CROUPOUS PNEUMONIA.—This remedy affects especially the lower lobe of the right lung. Among the symptoms indicating its use are: Dry, hoarse cough; expectoration of bloody mucus; throbbing headache; crepitant râles over lower lobe of right lung; intense thirst; headache worse when coughing; dulness on percussion over lower lobe of right lung. In a case reported, the patient had a chill two days previous, followed by high temperature and cough. As soon as physical signs developed to warrant a diagnosis of right-sided pneumonia, iodine tincture, thirty drops in a glass of water, was given, one teaspoonful every ten minutes. This occurred at 6 o'clock in the evening, the temperature being 103½. Two hours later the temperature was 101½. Twenty-four hours later the temperature was normal, and did not rise again. The headache was relieved, and all other symptoms gradually subsided. The same medicine was continued twenty-four hours longer at intervals of two hours, when the patient was apparently well. The diet consisted of milk and water *ad libitum*. No stimulants, poultices, or other adjuvant treatment was used.—*Ibid.*

LACHESIS IN ACUTE LARYNGITIS.—Boy, æt. 16 months. Respiration difficult, harsh, rasping, and stridulous; voice hoarse, at times almost lost; all symptoms worse after sleep; paroxysms of choking; paroxysms of a croupy character; stenosis of the larynx; during paroxysms of choking the head is thrown far back and the patient clutches at the throat; little or no difficulty in swallowing. Several remedies had been given with no apparent relief. While watching the child, with little hope of saving him, it was noticed after each little nap he had a severe attack of strangling. On this indication, "worse after sleep," *lachesis* was given with most satisfactory results. It was continued for several days, giving way finally to *calc. sulph.*, which completed the cure.—*Ibid.*

GELSEMIUM IN RIGID OS.—Lady, æt. 22, married two years, during which time sexual intercourse was impossible owing to vaginismus. Shortly after treatment for vaginismus she conceived, and at the seventh month gave birth to a male baby, well developed but very small. Dr. W. S. Fralick, who reports the case, was called in about 9 in the evening, but found no indications that delivery would occur that night; os undilated, but not more than ordinarily tense. Next morning the os was slightly dilated, but more hard. The same condition was found to obtain at 10 o'clock that evening, the pains coming every twenty minutes. *Gelsemium* was prescribed, a dose to be taken every five minutes. The effect was immediately perceptible to the finger which was held to the os, and the patient was delivered in twenty minutes.—*Ibid.*

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A CONTRIBUTION TO PLASTIC SURGERY.

BY WILLIAM B. VAN LENNEP, A.M., M.D., PHILADELPHIA.

THE subject of reconstructive or reparative surgery, as well as that of preservation so closely allied to it, has been particularly impressed upon my mind during the past year. For this reason, as has been my custom in the past, the annual meeting of the State Society seems an appropriate occasion to bring the subject up for discussion.

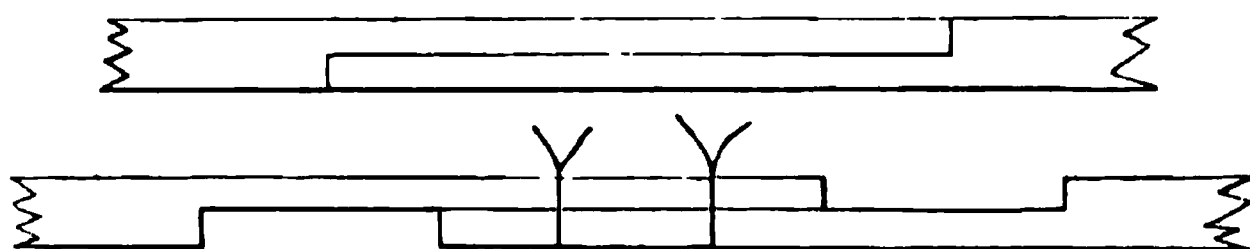
In looking over my table of operations since the last meeting, I have selected, from quite a number, the following ten cases which may be taken as more or less typical of the work done on these lines :

I.—*Vicious union of ulna and radius ; contracture of flexor muscles ; osteotomy and osteoclasis ; tendon lengthening ; cure :*

W. E., boy of 8 years, referred to me by Dr. C. G. Abbot, of Woodbury, N. J. He had sustained a fracture of both bones of the right forearm several months previously ; union had taken place at an obtuse angle, and there was an accompanying contracture of the flexor muscles of the forearm. The extent to which the fingers and wrist could be extended is shown in Fig. 1. Considerable callus could be felt between the bones, and, thinking the contraction might be due to adhesions, massage, and passive and active motion were

given a thorough trial for three months, when operative interference was consented to and undertaken.

The palmar surface of the forearm was incised from the annular ligament to above the seat of fracture; this latter was exposed in the radius, and the bone divided with the osteotome. The ulna was broken across the knee. The muscles were separated, and examined carefully down to the bones and interosseous membrane. No adhesions were found, and the contracture did not disappear after the deformity was corrected. Lengthening of the tendons was then undertaken, just above the wrist, according to the method of Anderson.



The superficial and deep flexors of the fingers, the long flexor of the thumb, the flexors of the wrist, and the palmaris longus were successively lengthened, until the deformity was found to be completely overcome. The amount of lengthening necessary for this purpose varied from one to one and a half inches, approximately.

The wound was tamponaded with iodoform gauze, and dressed with sterile gauze. At the end of a week the tamponade was removed, the wound tightly closed with a buried suture of catgut without drainage, dusted with iodoform (one part) boric acid (three parts) corrosive sublimate (one to five hundred), dressed with sterile gauze, and put up in a starch cast. As usual, the strictest antiseptic precautions were taken throughout.

At the end of two weeks the dressing was taken down, and the wound found healed, with the bones in good position. This was repeated twice a week for six weeks, passive motion, massage, and Faradism being given each time, when he was sent home from the Camden Homœopathic Hospital for Women and Children, where he occupied a private room. The same treatment, without any splint, was kept up for two months longer, when the cure was complete. The result is perfect as regards function and the amount of extension, as the hand lies easily on a flat surface, is shown in Fig. 2. The cicatrix is slightly adherent to the tendons, and moves with them somewhat.

II.—*Old, traumatic rupture of the membranous urethra ; complete occlusion of urethra ; urinary fistula in thigh ; urethroplasty ; cure :*

In 1884, the patient, while walking along a fence, fell astraddle of it, striking his perinæum. Only a few drops of bloody urine were passed, and, as the catheter could not be introduced, the bladder was aspirated a number of times. A week later a large perineal abscess was opened. This was followed by recurring abscesses, and finally, a fistula through which all the urine was passed. In 1887, he entered one of the large Philadelphia hospitals, and was operated a number of times, but the fistula persisted, and soon all the urine was again discharged through the perinæum. Abscess after abscess appeared, until he came under the care of Dr. A. F. Brandt, of Harrisburg, Pa., who sent him to me.

Examination, November, 1892, showed the following condition :

No instrument would go through the urethra, all being arrested in the bulb. In the median line of the perinæum was the cicatrix of an external urethrotomy completely healed and soft. To the left of this was a mass of cicatricial tissue, which extended for some distance down the inner side of the thigh, where there were a number of fistulous openings through which all the urine was passed.

The patient was anæsthetized eleven times, to which might be added fifteen more previously, and a number of measures were undertaken, although each procedure does not represent a separate sitting or operation :

1. Epicystotomy to divert the urine, with the introduction of a catheter-à-demeure (Skene-Goodman) through the suprapubic opening. This had to be changed from time to time as it became encrusted with phosphates. The irritation it produced was combated by frequent irrigations, but it became so severe, finally, as to preclude sleep, while the straining brought on very troublesome hæmorrhoids. As soon as the catheter was removed the suprapubic fistula healed spontaneously, the urinary distress disappeared, and the hæmorrhoids ceased to trouble him.

2. Perineal urethrotomy, by means of which were found the posterior end of the membranous urethra, well under the pubic arch, and the proximal end of the anterior urethra close to the edge of the scrotum. There was a gap between these ends of fully an inch and a half, and it was of course impossible to approximate and suture them.

3. Excision of the mass of cicatricial tissue which filled the right half of the perinæum and extended down the thigh, leaving a large raw cavity.

4. Complete dissection and removal of the inner layer of the prepuce (Wolff, Wölfler), which was transplanted as a graft ($1\frac{1}{2}$ by $\frac{3}{4}$ inch) to form the roof and sides of the new urethra. This took partly and failed partly, the result being a good roof but raw sides.

5. The application of skin grafts after the method of Thiersch to the sides of the urethra. This was successful, every graft taking.

6. Closure of the gap in the perinæum and thigh by sliding and twisted flaps and Thiersch skin grafts. The flaps were obtained from the thigh and the side of the scrotum; the grafts were taken from the abdomen.

7. Formation of the floor of the urethra by a reversed flap, pedunculated and twisted, the skin surface toward the urethra. This required two sittings, as the first attempt was a failure, and its raw surface was covered by sliding flaps and skin grafts (Thiersch and Reverdin).

8. Internal urethrotomy, first with the Maisonneuve and then with the Otis dilating urethrotome, to divide a linear stricture on the roof of the urethra at the junction of the anterior end of the grafts with the mucous membrane. This stricture, being partial, has not recurred.

9. Sounding under ether, then under cocaine, and finally without any anæsthetic, the patient at present taking without difficulty a No. 38 (Charrière) curved, conical sound.

10. Cauterization of three small fistulous openings which resulted from tension on one of the flaps, with the actual cautery, potassa fusa, and nitrate of silver stick, until the perinæum is now firmly and definitely healed.

At present his condition is an interesting and instructive one: The urine is passed entirely per urethram and the stream is thrown with considerable force. Erections and nocturnal emissions occur with their previous normal frequency, and, while some semen is ejected, most of it remains in the urethra and has to be squeezed out. The loss of the compressor urethræ muscle—the voluntary as well as surgical sphincter of the bladder—is also shown by the fact that the calls to urinate must be answered promptly, and if they are neglected too long, the urine gushes out involuntarily. Strangely, this seems to be gradually decreasing. The capacity of the bladder has improved greatly since the suprapubic catheter was removed, and is now normal. He urinates three times during the day, on retiring and arising, and does not have to get up during the night. The contraction of the numerous scars on the right side of the perinæum has shown itself by drawing the urethra slightly in that direction,

and this must be remembered in sounding. As might be expected, the mental condition shows a very marked change for the better.

III.—*Excision of dura mater; closure of the defect with transplanted graft from the pericranium; healing:*

I. G., æt. 29, had been subject to epileptic seizures for a number of years. They began in the left lower extremity, spread to the upper, and then became general. Loss of consciousness was inconstant. With intermissions of a few days he had these seizures several times daily, and they lasted from five to fifteen minutes. Their supposed origin was a traumatism. There was a scar over the left parietal eminence, in which region the skull had been explored, and there was excessive tenderness and pain at a corresponding point on the other side of the head. A deep stricture had been cut through the perinæum, and a ring of hæmorrhoids had been removed. He denied syphilis.

Operation, at the Hahnemann Hospital, July, 1893. The scalp was laid back in a large semi-circular flap, and the trephine applied over the upper portion of the fissure of Rolando. In this region, and backward and toward the middle line, the skull presented a decided hyperæmic appearance, bleeding quite freely, in marked contrast with the surrounding normal bone. The trephine opening revealing nothing, the rongeur was used, working backward and toward the middle line, until quite a large aperture was made. About an inch posterior to the trephine opening and at the point of greatest external sensitiveness, the dura was intimately attached to the skull, much thickened, and apparently bony. The same condition was found on its inner surface, from which there projected a good sized piece of bone. This portion of the dura was excised, leaving a gap one and a half by one inch in size. To prevent hernia, Keen's suggestion was followed: a piece of the pericranium was dissected off, trimmed down to fit the opening, into which it was stitched, with the osteogenic side outward. The scalp was closely sutured with fine, iron-dyed silk (buried), except at the most dependent portion, where a thin strip of iodoform gauze was inserted as a capillary drain. This was removed in forty-eight hours, and the wound healed throughout without reaction or suppuration.

It is too early yet to speak of the result. There were several convulsions, and left-sided hemiplegia, immediately after the operation, but the latter has disappeared, and the former recur at long intervals. There is no tendency to hernia of the brain.

IV.—*Large floating spleen ; suspension in place until attached by the induction of plastic inflammation :*

Mrs. A. M., æt. 35, had been the rounds of the Philadelphia hospitals for a pelvic tumor that had been variously diagnosed. I first saw her on the operating table, under ether, at the Camden Homœopathic Hospital for Women and Children, when it was very easy to lift the tumor out of the pelvis, and recognize the spleen enlarged to about ten times its normal size. It could readily be moved to any part of the abdomen. From her history and subsequent inspection I judged the enlargement was of malarial origin. The symptoms were those of pressure and traction on the pedicle. Excision would have been very easy.

The abdomen was opened in the middle line, the pedicle untwisted, and the organ pushed up into place. Another opening was made just below the border of the ribs, and suture to the abdominal wall attempted. The stitch tore out. A strand of heavy silk was passed with a needle into the abdomen, close to the spinal mass of muscles, as high up as possible, guided by the hand inside, and then out again in front. By throwing this loop around the spleen, drawing on it and tying the ends on the outside, the organ was held well up in its normal position. Through the opening in the side, the peritonæum lining the abdominal wall and the under surface of the diaphragm, as well as the capsule of the organ, were thoroughly scarified. Iodoform gauze was freely packed between the spleen and the abdominal wall, and the median incision sutured layer by layer with buried catgut.

Drs. Howard and Woodward, surgeons to the hospital, conducted the after-treatment, and I did not see the patient until some two months afterward. She made a rapid and uninterrupted recovery without an untoward symptom. The median incision healed *per primam* ; the gauze tamponade was gradually withdrawn, and, when adhesion was found complete, the suspending loop was removed. When I saw her, the organ was firmly held in place and all her symptoms had disappeared.

The firmness of such peritoneal adhesions is too well known to require comment. In anchoring the kidney plastic inflammation is encouraged by many operators, but the stitches are needed besides, as the scar of connective tissue will yield very much more readily than the adhesions of a serous surface.

V.—*Excision of recurring mammary carcinoma ; closure of defect by sliding flap and skin grafts ; healing :*

Miss R. C. W., 44 years of age, had the left mamma removed by the "dinner plate" incision at the Hahnemann Hospital in February, 1892. The large wound healed very slowly by granulation, the cicatrix breaking down and closing again and again, until a recurrence showed itself in the adherent scar.

The growth together with the entire cicatrix were excised, the incision being carried into healthy tissues. The pectoralis major was removed entire, and the axilla, which had been cleaned out at the former operation, opened, but found free from disease.

The patient having a fair amount of adipose, and the skin being freely movable, a curved incision was carried around the side to the back, and a large flap slid over the raw surface. The wound was closed with a buried suture of fine iron-dyed silk without drainage, except at a spot, one and a half by three-quarters of an inch in size, which the flap would not cover. This was closed by Thiersch grafts taken from the thigh. As usual the most rigid antisepsis was employed, and the wound dressed with iodoform gauze wrung out of bichloride solution, wet sublimated gauze, sterile sheet cotton, bandages and adhesive strips. The grafts were dressed with protective changed every other day. They all took. The wound healed without reaction or pus, and this in spite of the formation of two sloughs from tension, which were kept aseptic by frequently-changed wet bichloride dressings. The small defects left by their removal healed by granulation. These, as well as the wound and flap are shown in Fig. 3. The silk has not been heard from.

The resulting cicatrix is very satisfactory, being but moderately adherent, and containing a minimum of scar tissue, while the enormous defect is covered with normal, soft, pliable skin, with a good padding of fat, and shows no tension, which annoys such patients very much when a large wound like this heals by granulation. This plan has been followed now quite extensively in my private practice and in my hospital service, and I find that it gives the ideal result. Whenever practicable, in any portion of the body, after a defect is left by any operation, I have recourse to this plan of sliding flaps. Next to it and far superior to the cicatrix resulting from healing by granulation is the method followed in case VI.

VI.—*Excision of carcinomatous breast; immediate closure of defect by skin grafts; healing:*

Miss C. Z., æt. 54, private patient at the Hahnemann Hospital, operated September, 1892. Examination showed the right mamma to be completely filled with a stony-hard growth, which was after-

ward found histologically to be a carcinoma with excessive stroma. The skin was not ulcerated, there was some fixation to the chest-wall, and several nodules could be felt in the axilla. The breast was removed by the "dinner plate" method, the pectoralis major excised, the minor pectoral divided (Halstead), and the entire axilla thoroughly cleaned out. A number of infected glands of varying size were found. The enormous wound was drawn together as much as possible, with interrupted sutures of silk and a continuous buried suture of catgut. The patient was so thin and the skin so inelastic, that a large raw surface remained, and sliding flaps were out of the question. Thiersch grafts were at once taken from the thigh, which had been previously prepared, and the entire defect covered with them. Hartley's razors answered admirably for this purpose. The sutured wound was dusted with iodoform-boric-sublimate powder, the grafts covered with strips of sterilized protective taken from salt solution, and the whole dressed with sterile gauze, woodwool, and a bandage held in place with adhesive strips. The grafts were dressed every other day and "took" with one exception, this defect being closed by Reverdin grafts kindly supplied by one of my students. The rest of the wound healed under one dressing, and her physician, Dr. G. D. Woodward, of Camden, N. J., reports no recurrence as yet. Unfortunately an early photograph was not obtained. I have employed this method, suggested by Watson Cheyne, in a number of cases, and can heartily recommend it where sliding flaps are unavailable. Either of these plans hastens healing immensely, and does away with the deplorable "invitation to return" held out by the ordinary slow process of granulation, with its easily ulcerating scar tissue, long continued irritation, adherent cicatrix, and painful contraction and contractures.

VII.—*Excision of carcinoma of the cheek; closure of defect by sliding flaps; healing:*

R. S. D., æt. 48, private patient, operated at the Hahnemann Hospital. An epithelial carcinoma of the right cheek and side of the nose was excised in June, 1893, leaving the defect shown in Fig. 4. The ulcer had been previously treated with caustics, causing extensive cicatricial contractions in the surrounding tissues. As a measure of safety, the dissection was carried so deeply that the nasal cavity was laid open. The extent of this opening is shown in the photograph.

A week later, a flap was formed by a curved incision in the cheek, carried downward and outward, which was slid over to close the defect. The result is shown in Fig. 5.

FIG. 1.

FIG. 2.

FIG. 3.

FIG. 4.

FIG. 5.

FIG. 6.

FIG. 7.

FIG. 8.

Fig. 10.

Fig. 9.

Owing to tension, or, more probably, to impaired blood supply, the portion of the flap covering the nose sloughed, leaving the nasal cavity open. After healing was complete, another flap was dissected off of the above flap, under cocaine, and slid over this defect. This apparent mishap was really a fortunate occurrence, for the sliding of the second flap thinned the cheek which was thicker than the other side, and gave a slope to the nose, which was obliterated by the original thick flap. Rapid healing followed the second plastic operation, and the patient was sent home to the western part of the state with a small sinus communicating with the nasal cavity. Unfortunately, I have not yet received the final photograph which would show a decided improvement on Fig. 5.

VIII.—*Excision of recurring carcinoma of the right side of the neck (secondary to carcinoma of the lower lip) with resection of the lower jaw ; closure of the defect by sliding flaps ; healing :*

W. A. L., æt. 65, patient of Dr. T. O. Clements, of Dover, Delaware. Two years previously I removed a large carcinoma of the lower lip, closing the defect by the sliding method of Celsus, using a higher incision of the mucous membrane to form a new lip. The scar of the operation shows in Fig. 6. Six months previously, Dr. John E. James, my surgical colleague in the Hahnemann Hospital, removed, by an extensive and thorough operation, a number of cancerous glands from the right side of the neck. The wound did not heal, and he returned again in March, 1893, presenting the appearance shown in Fig. 6, and insisting on another operation.

Excision of the growth necessitated a resection of over half the lower jaw, which was, so to speak, eaten into, and a careful dissection of the tissues attached to the larynx, œsophagus, and great vessels of the neck. The mouth was opened, too, to a large extent. The resulting cavity is shown in Fig. 7. The wound was packed with iodoform gauze, and, a week later, a flap was loosened, by a curved incision, from the side and back of the neck, and slid over to cover the defect. The tension was so great as to produce symptoms of asphyxia, and the nurse was instructed to cut the sutures should such a condition become imminent. The elasticity of the skin was sufficient, however, to allow of rapid primary union, and the patient was discharged with a small fistula communicating with the mouth. Fig. 8 is from a photograph taken a few days since, when complete and definitive healing had taken place. The only visible defect is the absence of the beard on the flap which came from the back of the neck. In another photograph, showing the full face, this is not noticeable.

IX.—*Crushed foot; gangrene of three toes and dorsum of foot; amputation of toes and removal of slough; skin grafts; cure:*

R. D., æt. 17, Italian laborer, was sent to the Hahnemann Hospital by Dr. Thomas Reading, of Hatboro, Pa., in June, 1893. A large stone had fallen on his left foot, crushing the three inner toes and the dorsum of the foot, and fracturing the two inner metatarsal bones. The three toes soon became gangrenous, and the process spread rapidly up to the ankle, involving almost the entire breadth of the foot. The parts were dressed antiseptically, and carefully watched, until the line of demarcation was clearly defined, when he was operated.

The three toes were amputated, and it was found possible to partially cover the heads of the metatarsal bones by forcibly drawing forward the sole. The slough on the dorsum was dissected off, and the skin drawn together from the sides and down from the ankle, with considerable tension, to reduce the defect as much as possible.

Two weeks later, after the surface had been prepared by frequently changed, wet, bichloride dressings, and the foot and thigh had been thoroughly scrubbed and disinfected, he was etherized and the granulating surface covered with Thiersch skin grafts. They were treated in the ordinary manner, and every one took. The resulting cicatrix, after complete healing and contraction, is shown in Fig. 9. He was discharged with a perfectly useful foot.

X.—*Crushed elbow; excision; close suture; superficial gangrene; skin grafts; cure:*

C. D., age 19, was brought by the patrol to the Hahnemann Hospital, August 1, 1893. His left arm, at the elbow, had been run over by a horse car. The lower end of the humerus and the upper end of the ulna and radius were ground almost to a powder; the muscles and skin were extensively crushed and torn, and, with an intimate admixture of dirt and grease, resembled a filthy pulp. The wound and arm were scrubbed and disinfected vigorously and thoroughly, the cavity packed with sublimated-iodoform gauze, and the whole put up in a wet bichloride dressing. I saw the case the next day, and, finding pulsation at the wrist; at his urgent solicitation, after he had been impressed with the probable dangers, decided on a conservative course.

The comminuted joint was cleaned out, leaving smooth humeral, radial, and ulnar stumps, and the cavity allowed to fill with a blood clot. After careful trimming, the muscles and deep fascia were closely sutured with iron-dyed silk. The ulnar nerve was isolated

and preserved. The skin and subcutaneous tissues were crushed beyond recovery, but, guided by former experience, I decided to continue the close suture without drainage, relying on keeping the slough aseptic.

Besides, in carefully watched hospital cases, even if infection takes place, it is an easy thing to open a wound and arrest the process. I have gone so far in this direction as to amputate a forearm, at the edge of a stinking, sloughing, phlegmonous erysipelas; pack the wound, and, at the end of three days, closely suture it without drainage. Healing followed with but slight suppuration, and this in spite of the fact that the pyæmic process had affected the opposite elbow, and the patient when operated was in a low, muttering delirium, and in profound collapse.

The pulpy skin was accordingly sutured with buried silk, without drainage, and the arm put up in wet, sublimated dressings; the inner layer iodoformized. They were frequently changed.

All the tissues, down to the deep fascia, over the posterior surface of the elbow became gangrenous and were removed as soon as loose. The extent of this superficial necrosis is shown in Fig. 10, in which are also seen the Thiersch skin grafts. In spite of this process the muscles and fascia united by first intention without being infected, and presumably the moist blood clot remained intact. There was a smart febrile rise for the first few days, reaching 102° , but a careful study of this showed only a slight zigzag, no more than could be accounted for by the necrotic process; so the deeper portions of the wound, and, for that matter, the superficial portions too, were not touched.

Eighteen days after the first operation the sloughs having been cleaned off and the granulating wound thoroughly disinfected, the whole defect was covered with grafts taken from the thigh. Their appearance is shown in Fig. 10. Unfortunately, only about three-fourths of them took, this partial failure being due, I am sure, to faulty technique in the primary or subsequent dressings. At the close of my hospital service for this year, September 1st, this portion of the wound was rapidly cicatrizing, and, judging from the function already present, and the results obtained in two almost identical cases last spring, I think he will have a useful arm.

The granulating wound, before and after the use of grafts, was dressed with a 5 per cent. emulsion of balsam of Peru in castor oil, well rubbed into absorbent sterilized gauze. This was covered with occlusive material, such as sheet cotton, wax paper, or oiled silk. I

have experimented quite extensively, in the dispensary and hospital, with this dressing, suggested by Van Arsdale, for granulating wounds, and with such satisfactory results as to lead me to adopt it in private practice.

Apropos of the primary rise of temperature, the following recent case at the Hahnemann Hospital seems in point :

A large suppurating lymphoma of the groin and Scarpa's triangle was thoroughly excised, the greatest pains being taken to render the cavity sterile by mechanical as well as chemical means. A close, buried suture of silk was then-made, allowing the underlying cavity to fill with a blood clot, a small gauze drain being slipped into the lower portion of the wound which was not considered completely aseptic, and which had been shut off from the rest with the suture. The temperature rose rapidly to 106° , and then very slowly, but steadily, came down without any zigzag. The wound was inspected daily until the temperature became normal, but there being no signs of inflammatory reaction it was not opened. The blood clot filling the large cavity probably caused the "aseptic fever" of "fibrin absorption." At the end of two weeks the gauze drain was removed from a small granulating sinus, the rest of the wound being completely healed *per primam*.

ANGINA PECTORIS.

BY E. M. HALE, M.D., CHICAGO, ILL.

(From Dr. Hale's *Practice of Medicine*—In Press.)

THIS affection is sometimes called steno-cardia and breast-pang. It is not an independent affection, but a symptom connected with several diseases of the heart and bloodvessels, especially with changes in the coronary arteries and sclerosis of the roots of the aorta. True angina is a rare disease. It is characterized by paroxysms of excruciating pain in the region of the heart, extending into the arms and neck, and occurs almost exclusively in men of adult age. The real pathology is yet uncertain. In most cases, there is present aortic insufficiency, increased arterial tension, hypertrophy of the heart, or arterio-sclerosis. The immediate causes of attack are, generally, sudden exertion or emotional excitement. The paroxysms often oc-

cur at night, but may appear in the daytime. I have seen two cases where it invariably occurred after smoking a strong cigar.

Several theories have been advanced as to the nature of the affection, namely: 1. Neuralgia of the cardiac nerves. 2. Heart-cramp. 3. Extreme distension of the ventricular walls. 4. Sclerosis, with narrowing of the coronary arteries. 5. Vaso-motor spasm of the coronary or peripheral arteries.

I believe it may be caused by each of the above conditions, and, perhaps, others not yet mentioned.

Symptoms.—In true angina, the patient is suddenly seized with an agonizing pain in the region of the heart, and a feeling of constriction as if the heart was seized in a vise. Then, pains radiate up the neck and down the arms—generally the left—and there may be numbness in the fingers, or in the cardiac region. The face becomes cold, pallid, ashy-gray, covered with a cold sweat, which may extend all over the body. Actual dyspnoea is not usually present in true angina. The paroxysm may last several seconds, or a minute or two, during which the patient feels as if death were impending. The patient may drop dead at the height of the attack, or pass away in syncope.

The condition of the heart during the attack is variable. Strange to say, its beats may be uniform and regular, even the character of the pulse may be normal. After the attack the patient feels exhausted, and suffers as after a severe fright. Eructations and passage of large quantities of clear watery urine is common. He may rally in an hour or two, and feel quite like himself, or be confined to his bed for several days. The attacks may occur every few weeks, or not for years, and during the intervals the patient may feel quite well.

It is sometimes difficult to diagnose true from false angina pectoris. The subjective symptoms do not afford a reliable guide. We must rely upon an examination of the circulatory system. Even in mild forms of true angina, signs of arterio-sclerosis are usually present. If, on auscultation, the aortic second sound is clear, not ringing, the pulse-tension is low, the peripheral arteries soft, and the pulse compressible, the case is not one of true angina.

False angina is a common affection in nervous women. It is generally hysterical, and the vaso-motor symptoms clearly present. Hysteria simulates true angina, as it does many other severe disorders, Dr. Huchard has given us the following concise points of diagnosis between the true and false angina:

<i>True Angina.</i>	<i>Pseudo Angina.</i>
Most common between the ages of forty and fifty years.	At every age, even six years.
Most common in men. Attacks brought on by exertion.	Most common in women. Attacks spontaneous.
Attacks rarely periodical or nocturnal.	Often periodical and nocturnal.
Not associated with other symptoms.	Associated with nervous symptoms.
Vaso-motor form rare. Agonizing pain and sensation of compression by a vise.	Vaso-motor form common. Pain, less severe; sensation of distension.
Pain of short duration. Attitude: silence, immobility.	Pain lasts one or two hours. Agitation and activity.
Lesions: sclerosis of coronary artery.	Neuralgia of nerves (?) and cardiac plexus.
Prognosis: grave, often fatal.	Never fatal.
Arterial medication.	Anti-neuralgic medications.

The pain in the left side in the region of the apex of the heart, from which nervous and hysterical women suffer, is often so severe as to simulate true angina; but, the location of the pain, and the fact that the patient is capable of agitated movements during the paroxysm, shows the real nature of the paroxysm.

Prognosis.—If the patient has arterio-sclerosis, or aortic insufficiency, the prognosis is bad; for, sooner or later, death will occur in one of the paroxysms. Sometimes, however, with judicious treatment between and during the attacks, a complete recovery may be obtained.

Neuralgic angina may prove fatal in delicate persons with weak heart. Pseudo angina never kills, although it may make life a burden.

Treatment—Treatment of the paroxysm. In true angina, the duration of the attack is usually so brief that no medicine, except amyl nitrate, acts quickly enough to give relief. One to five drops of this volatile liquid, inhaled from a handkerchief or vial, will give prompt relief. The subjects of this disease should carry with them the pearls containing a few drops of amyl. These are crushed in the hand or in a handkerchief and rapidly inhaled. In one case, under my care, the patient absolutely refused to have anything come near his mouth—it “suffocated him.” I injected three drops mixed with ten of water under the skin, and the relief was almost instantaneous.

Glonoine can be administered in the same manner, and will act quicker than when given by the mouth. Chloroform does not act quickly enough to arrest a paroxysm of true angina, which rarely lasts longer than a fraction of a minute. In pseudo and hysterical angina, in strong girls, chloroform may be given, and often arrests

the paroxysm quickly. Morphia is of no value in heart-cramp, but is of value in pseudo angina. I have met with several instances in women, in which the pain was in the right side near the axillary line, but I am sure it was of the same nature as the pain in the left side from ovarian irritation; yet, it simulated angina very closely. Some of these cases yielded in a short time to cimicifuga; others were so severe that hypodermic injections of one-eighth grain morphia had to be used.

In the various forms of angina, if the heart is weak I would not advise the use of phenacetine. In all other instances I value it highly as a safe and efficient remedy. In mild cases a grain every half-hour will suffice. In severe cases one or two doses of five grains rarely fails to relieve. It is unfortunate that this useful medicine cannot be given hypodermatically on account of its insolubility.

General Treatment.—In all forms of angina the patient should lead a quiet life, avoiding all mental excitement and sudden severe physical exertion. If arterio-sclerosis is present, the diet and regimen should be regulated (see article on “arterio-sclerosis.”) There are a few medicines which appear to have an influence in arresting or retarding the progress of degeneration going on in the arteries. Dr. Huchard of Paris, France, finds that the iodides have this power if their use is prolonged. He prescribes twenty grains three times a day for several years, omitting the medicines ten days in each month. He cites the cases of two men, both arterio-sclerosis, ringing accentuated second sound, and attacks of true angina, who, under its use, remained practically free from attacks—one for nearly three, and the other for fully four years. In one case of my own, the patient was made nearly free from attacks by the use of ten grains of iodide of soda thrice daily for two years. Not all patients are tolerant of the drug, nor does it always bring about improvement.

Osler says he has several patients who were not at all improved by the iodides. Some patients may be intolerant of one iodide, and tolerate another. Iodide of potassa acts best in persons of strong muscular development. If the muscles are weak, iodide of soda acts better. The iodide of strontium acts well in patients with delicate stomach, and possesses the advantage of not causing acne.

Aurum is an excellent remedy in arterio-sclerosis, in which there is an element of vaso-motor constriction. Aurum meret sodii, or the iodide of gold, has in several cases given me good results. The dose is three to five grains of the 2x ($\frac{1}{100}$ to $\frac{1}{30}$ grain) three times a

day. It should be continued for many months, with intervals, especially if pathogenetic symptoms appear.

Glonoine (nitro-glycerine) is not only a valuable palliative in angina, but is of great value during the interval. I refer to its physiological action. In doses of $\frac{1}{100}$ or $\frac{1}{50}$ grain, it relaxes the arteries even in arterio sclerosis. In doing this it relaxes the heart-muscle and prevents heart-cramp. The dose should be sufficient to give a soft, large pulse without causing disagreeable headache. In some patients this result can be obtained with $\frac{1}{200}$ grain every four or six hours. Others require $\frac{1}{50}$ grain, and several cases are reported requiring and tolerating $\frac{1}{2}$ grain. It can be given with other medicines, and does not seem to antagonize them. If these medicines fail to cure, or cannot be taken, there are several possible remedies which should be tried according to the law of *Similia*.

The poison of lachesis, naja, the scorpion, latrodectus and some other venomous reptiles causes attacks similar to angina pectoris. The sting of apis and some other insects have also caused pain and constriction in the region of the heart.

The provings of latrodectus give some very characteristic symptoms. Dr. E. H. Linnell, of Norwich, Conn., reports the following case treated with latrodectus:

"S. L. G., a man fifty years old, of bilious temperament, a dentist by profession, had slight attack of angina after severe exposure and over-exertion in the "blizzard" in March, 1888. He did not consider them of sufficient importance to consult a physician about them, but some months later he had a suppurative prostatitis, which was followed by considerable prostration, and the attacks of angina became very severe. I never could get a satisfactory description of the character of the pain, and I never saw him during a paroxysm; the pain was brought on by exertion of any kind, and was especially frequent soon after dinner. The pain was sometimes felt in the left arm, but was usually confined to the cardiac region. I once or twice detected a slight aortic obstruction sound, but aside from this failed to find any evidence of organic disease. The usual remedies gave no relief, but latrodectus 3c. was of great benefit. Under its use the attacks gradually became less frequent and less severe. He has taken no medicine now for at least six months, and he tells me that although he occasionally has a little reminder of the former trouble, the attacks are so slight that he pays no attention to them. I have given the remedy in another similar case, with even more gratifying success. The attacks were

promptly arrested, and have not returned, although nearly a year has elapsed."

Cactus grandiflora takes the front rank as a homœopathic remedy in angina pectoris. It may not influence well-developed sclerosis of the arteries, but it is perfectly indicated in vaso-motor, neuralgic, and pseudo-angina. The characteristic symptoms are: the constriction of the heart "as with an iron band," and a tenseness of the pulse, with a narrowing of the arteries. All the cacti which have been proven show this symptom in a greater or less degree.

Anhalonium, probably the most poisonous of all, ought to be equal to *cactus*. The dose should not exceed the 1x dilution ($\frac{1}{10}$ of a drop) every four or six hours, in the intervals; during an attack, every five minutes. *Arnica* is indicated when the attack arises from sudden strain, as in lifting. If the patient will keep quiet for a few days, *arnica* will prevent further attacks. *Rhus tox.* ought to be useful under the same circumstances.

Coca and *cocaine* have produced symptoms similar to angina pectoris. Several persons have died under toxic effects, presenting such symptoms. Struggling for breath, with cold, clammy extremities, indicate its use. Tincture of *coca*, a few drops every ten minutes, or the 2x trituration of *cocaine*, is the proper dose.

Quebracho, or its alkaloid, *aspidospermine*, is indicated for the same symptoms, and in the same or somewhat larger doses. It is especially useful when walking brings on the intense dyspnoea and constriction of the whole thorax. The old school unanimously assert that all the cardiac tonics, *digitalis*, *convallaris*, *adonis*, *nux vomica*, *strychnia*, *oleander* and others, are not to be given in the treatment of angina pectoris. They declare, rightly, that they are dangerous. The reason lies in the fact, which they are cognizant of, that all such medicines produce similar symptoms by causing vaso-motor constriction and violent contraction of the heart-muscle.

Now, if any of these cardiac medicines are indicated by the symptoms, they will be useful in all the forms of angina pectoris, except in advanced arterio-sclerosis. The dose should be small, never exceeding a drop of the 1x dilution. Several other medicines have been recommended for angina, among them *aconite*, *arsenicum iodide*, *asafoetida* (hysterical), *cimicifuga*, *cuprum*, *lilium*, *moschus*, *kalmia*, *spigelia*, *tabacum*, and *veratrum alb.* Of these, *cimicifuga* is useful in spurious angina, when a reflex of uterine or ovarian disorders. *Lilium* ought to be of value in the same conditions, but I have serious doubts of the trustworthiness of its provings.

Magnesia phos., ferrum phos., and kali phos. are recommended by Shussler for angina pectoris, but there is nothing in their provings that warrant their use, and his so-called biological indications are purely theoretical. No clinical verifications have yet appeared that would warrant their use in this disease.

Some empirical remedies have been recommended. Dr. Henning says he gave *œnothra biennis* to an old man with angina; "twenty-drop doses gave him prompt relief."

Piscidia (Jamaica dogwood; several reports of its successful use in angina have appeared. It is recommended as a substitute for glonoine. The dose is from ten to thirty drops. I doubt its value in true angina, but it may be of value in pseudo, or hysterical cases. *Belladonna*, *hyoscyamus*, *solanum*, *lobelia*, *iberis*, may be useful in some instances.

THE INDIVIDUALITY IN THE REMEDY.

BY C. S. SCHWENK, M.D., PHILADELPHIA.

(Read Before the Homœopathic Medical Society of the State of Pennsylvania.)

IN the materia medica we have a whole world of individuals. To a stranger they may all appear alike, just as the individuals of the human race are all similar, yet no two can be found exactly alike; each is a separate and distinct being by itself, having its own peculiar characteristics and idiosyncrasy. It is only after years of study, coupled with practical application, that the individuality in the remedy manifests itself to the student. To hope for success in the medical treatment of disease, and by internal medication only can disease be eradicated from the human organism, it becomes incumbent upon the physician to acquaint himself with the remedies as he is with his personal friends. A man may find a stranger by having in his possession a detailed account of him, but an intimate acquaintance would recognize him the moment he saw him. He would know him by certain individual characteristics, possessed by him alone, which might even prove difficult to explain. It might be by any one feature, or all taken together—a peculiar walk, or manner of speech, or tone of voice—and so we must know our remedies. The sick will always give us a detailed account of some particular remedy, and we should be on such intimate terms with it that it would be like listening to the description of one of our personal friends.

How foolish appears the use of aconite in fever, when we know that every remedy in the materia medica has fever symptoms, each possessing its own individuality, separate and distinct from all the others, and that we can only corroborate our selection by fitting the remedy, in its *tout ensemble*, to that of the malady. What drug, in its proving, will not produce disturbances in the sensorium, alimentary canal, excretory organs, heart, lungs, back, limbs, etc.? From the nature of things, does not a cause tinge all its effects with its individuality? Does not the invasion of disease spread its characteristics throughout the organism? Then why be led by empiricism, and attempt to fill a round hole with a square plug? In the carelessness of routinism it may be made answer as a *similar*, but science requires the *similimum*, and an infallible guide to the selection of the similium is through the intimate acquaintance with the individuality which is to be found in every remedy.

We all know rhus toxicodendrum when we meet with it in disease; it may be in any of the fevers, in rheumatism, in sciatica, insomnia or a common cold, but always the same peculiar individuality presents itself. Rhus tox. and rhus radicans are usually regarded as being exactly alike in their effects, but they are not. Dr. Aug. Korndorfer has clearly defined a difference between them, which he has verified by the clinical experience of a number of physicians. The distinction is discoverable in the headache of the remedies. The rhus tox. has frontal and parietal pains, which latter extend towards the occiput. The rhus radicans pains begin in the occipital and sub-occipital regions, and, if they increase in intensity later, extend forward towards the forehead. That is all. Every other symptom of the two remedies is identical, one with the other. But the little difference gives two individuals, and one cannot take the place of the other, become the similimum and effect a cure. Call it "splitting hairs" if you please, but nature sets the task, and failure attends its evasion.

Let us briefly consider digitalis in its physiological action, and endeavor to discover its individuality. Its effects all seem to center on a weak and dilated heart, and by it there appears to be established a want of balance throughout the organism. This lack of resistance, due to a weak force in the blood-circulation, appears to allow an undue contraction of the circular muscular fibres, and, as a result, we find the peculiar characteristics of digitalis manifesting itself everywhere. The skin is universally pale; it is more than pale—it is white, sometimes bluish white. The pupils of the eyes

are not very active, the inclination is towards contraction ; this same contraction is to be found in the excretory organs : constant urging to urinate ; feeling of fulness, continuing after urination. Frequent desire to evacuate bowels, accompanying urging to urinate ; very small stools, without relief. *Whitish* or *ash-gray pipe-stem stools*, with aggravation in the early evening. The writer was afforded the pleasure, through the use of digitalis in dilutions ranging from the 6th to the 30th centesimal, of curing a case of chronic diarrhoea of twenty years' standing. The patient's general health did not appear to be depreciated to any extent ; it was a great annoyance to him. He was comparatively comfortable during the day, but as six o'clock in the evening approached, he would be seized with sudden urging to urinate and defecate. This would continue until nine P.M., when he would have relief until six o'clock the next evening. The stools were like long *white pipe-stems*, indicative of contraction of the circular muscular fibres of the rectum, and which appeared to manifest itself even in the liver, in preventing the excrement of bile through the proper channels. The skin was unduly white, and slightly tinged with yellow ; pupils contracted ; pulse at all times slow and weak, being about fifty per minute. Under digitalis we find choking when trying to swallow. Naturally the respiration is slow. Nausea and gagging is a prominent symptom of digitalis. But the most characteristic is the *slow* and full or weak pulse, becoming slower the more quietly the patient rests ; and so marked is this that in some instances the digitalis patient is afraid to lie absolutely still in one position for any length of time for fear his heart will cease beating. The anxiety of the remedy is marked in all cases, and seems to be centered entirely on the weak heart. This remedy seems nicely to exemplify the fact that a cause tinges all its effects with its individuality. To the botanist the field of weeds tells the story, and what are stones and rocks to the wayfarer, are ages of history to the geologist. The skeptic should not feel discouraged. Deep and persistent study, properly directed, will cast off traditional fallacies, and he will find reason leading him, through inductive philosophy, into something deeper than diagnosis and pathology, and comparative results will prove the wisdom of his pertinacity of purpose.

VESICULAR ERUPTION FROM MERCURY.—Dr. Mouffier treated a man of 45 years for traumatic orchitis with inunctions of mercurial ointment. Rigors set in with the development of red spots over the entire body, which soon passed over into large vesicles filled with serum, and were accompanied by violent pains. Recovery in ten days.—*Allgemeine Homœopathische Zeitung*, Nos. 25 and 26, 1893.

A SMALL CONTRIBUTION TO HISTORY.

BY CHAS. B. GILBERT, M.D., WASHINGTON, D. C.

HAHNEMANN is accused by some of being opposed to pathology and to be in favor of considering only symptoms, but in course of correspondence with Dr. C. Hering he said "if pathology is a science it must be taught" not *may* but *must*; that was also the position of Hering.

There lies before me a little work entitled *Key to the Materia Medica or Comparative Pharmacodynamic*, by Adolph Lippe, M.D., 1854; in the preface he says: "By *Characteristic Symptoms* I understand such symptoms as have been repeatedly produced upon the healthy and cured in the sick by each respective drug;" . . . "The more frequently a symptom has been produced and cured, the more it increases its *relative value* to the student of the *Materia Medica*; and while this symptom may often determine the choice of a remedy in a given case, pathology must determine the relative value of the various symptoms presenting to us the disease to be treated." Here we have *pathology* and *must* again.

What do we find that veteran devotee of Hahnemann and bosom friend of Hering doing? Why writing a work on *Pathology and Therapeutic Hints*, now in its third edition—Dr. Raue.

Are there many better pathologists than S. A. Jones whose work was approved by Carroll Dunham? And are there many Hahnemannian homœopathists who are superior in their strict devotion to the law than Dunham?

In the announcement of the Hering Medical College, which claims to teach homœopathy in all its strictness, appears "A complete course of lectures will be given on the subject of general pathology."

What more can be asked of the Hahnemannian or offered? But the pathological condition which is found in the patient is not treated, but rather the patient in whom is found the condition.

TREATMENT OF LEUCOCYTHÆMIA.—Dr. P. Jousset states that picric acid produces in dogs an artificial leucocythæmia. Dr Goulon claims to have found in thuya a remedy corresponding to medullary leucocythæmia. He, together with von Grauvogl and Lilienthal, recommend natrum sulphuricum, in the third decimal dilution, 5 drops three times a day. Jousset cannot support these claims, as they have not received clinical confirmation. Besides these, he advises bryonia, conium, mercurius, and phosphorus.—*L'Art Medical*, No. 6, 1893.

MITRAL INSUFFICIENCY.

BY THE LATE CHARLES ELMER LANING, M.D., CHICAGO, ILL.

IN studying a case, for the purpose of selecting the remedies best adapted to its cure, there are more things to be taken into consideration than is generally realized. The reflexes, which make their appearance in many instances, are often given an importance which they do not deserve; while again, they are passed by without giving to them their proper significance.

The causative relation which symptoms bear one to the other requires careful analysis, in order that the entire picture of the case may present to us the correct image of remedy and disease.

Who is there that, in childhood, has not watched with eager and wondering eyes, the innumerable changes occurring in the kaleidoscope, as by turning it he caused the various bits of glass to assume beautiful and strange forms? The child did not realize that all of these forms and colors were due to the simple fact that the *same* pieces were being grouped or arranged differently, and that if the red bit of glass be on the right or left it made a difference in the picture. In short, the whole thing depended upon the *relation* of one part to the other, and not to the introduction of any new elements.

With a medical case, the color, the form it assumes, so to speak, depends upon the relation one symptom bears to another. Is the pain in the head due to the bad feeling in the stomach, or, is the reverse the case? As in the kaleidoscope, the relation they hold to one another determines the form and color of the picture presented to the eye. There is a difference, however, between the kaleidoscopic picture and the disease picture. The one is presented entirely to the retina, and hence all eyes—if at all normal—see it as a wheel, a cross, or a triangle, which is red, blue, or green, or a combination of all these colors. The medical picture is more complex, and requires eyes, ears, and fingers, to detect the warp and woof of which it is constructed, and even after it has been done, it often requires careful, inductive, analytical reasoning, to give the proper form to the picture, and then say just what that form is, whether a circle, a triangle, a polygon, or an ellipse.

This being true, it is not strange that different medical men make different pictures out of the same group of symptoms. To one, it

looks like a circle, or brain-disease ; to another, it as surely represents a triangle, or gastric disease. As a result of this, various opinions are expressed by different physicians regarding a given case.

One more point before we take up the study of illustrative, practical cases. A symptom which is purely reflex to-day, and needs no attention from the therapist, may, to-morrow, or at least after a certain length of time, have ceased to be a reflex, as will be demonstrated by the fact that, although the lesion upon which it originally depended (to which it was a reflex) has been removed, the erstwhile reflex still remains.

This takes us somewhat into the domain of ætiology, and the therapist is greatly handicapped, unless he be a student of this branch of medicine. Strictly speaking, all the symptoms or evidences of disease with which we meet are reflex, that is to say, they are the *results* of some disturbing influence still back of them. Only when they have attained the power to maintain themselves, after the cause or influence which originated them has been withdrawn, do they deserve the title of idiopathic symptoms or lesions. These reflexes at times, indeed often, assist in maintaining the lesions upon which they depend, and prevent to a greater or lesser degree the efforts of the physician to remove them. Occasionally, an army may be decidedly harassed by the sharpshooters and skirmishers of the enemy, who may, to a degree, retard or prevent the repulse of the main body to which they belong. Is it not wise, then, to occasionally pay some attention to these men, who, alone, would be insignificant, and yet, as aids of the main army, wield considerable power ? To make the simile more closely correspond to what occurs in a medical case—suppose that the sharpshooters and skirmishers are constantly increasing in numbers and in their independence of the main division, each day improving and strengthening their intrenchments, and adding to their commissary department. Now, the general whom they are opposing might have noticed that they picked off some of his best officers and men, and that it was difficult to use his guns, since, frequently, they shot down his artillerymen. Suppose, in spite of this, he paid no heed to them, not even sending an occasional volley or charge against them, for the reason that he believed as soon as he should overcome the army opposed to him, all of these reflexes, all of these annoying shooters and raiders would, of necessity, disappear. What must be the surprise of such a general, when he at last succeeds in routing what he considered to be the main army (and which originally was), to find on his flank a new

army, well equipped and fortified—an army which has developed from the much-despised skirmishers. This is no fanciful picture, but has its parallel in medicine, if not in war, as I shall proceed to show.

Valvular diseases of the heart are not, as a rule, studied as they should be; that is to say, the reflex-symptoms are not properly taken into consideration. A diagnosis is too often based upon a single symptom or feature of a case, as headache, constipation, dropsy, etc., each of which simply represents a reflex symptom. What is the cause of the headache, constipation, or dropsy, is the first question the physician should ask himself, and if the diagnosis is to be made from a symptom, let it be rather the first one in the chain, instead of the last.

As an outgrowth of mitral insufficiency there may be present: gastric catarrh, nausea and vomiting, pyrosis, flatulence, hypertrophied liver, jaundice, hypertrophied spleen, ascites, hæmatemesis, melæna, scanty secretion of urine, albuminuria, œdema of the feet, bronchitis, hydrothorax, cyanosis of the face, congestion of the brain, œdema of the brain, œdema of the upper extremities, dyspnœa, orthopnœa, cough, œdema pulmonum, alternate diarrhœa and constipation, and general emaciation which is only masked by the œdematous conditions present. It is not enough to know that these complications, these symptoms, exist in cardiac valvular disease, but it must be understood how each one is produced, in order that its significance may be understood, as well as its reactionary effect upon the initial lesion. Until the physician has analyzed a case of this nature so that he knows how each symptom has been produced, how it is related to the primary lesion, and how the various symptoms are related to and affect each other, and how they all react upon the initial lesion—until he has done this, I say, he cannot treat such a case scientifically, in spite of the fact that he may select some so-called “characteristic” symptoms upon which to base his prescription. A knowledge of anatomy and physiology is all that is needed to enable the physician to make such an analysis. In a case of this kind we have a large number of vascular prefixes. Thus, given an insufficient mitral valve, it is plain that the pulmonary veins will have a back pressure in them; this is conveyed to the pulmonary artery, of which they represent the continuation. It is clear that this will cause more or less stasis of blood in the pulmonary tissue, which, if carried far enough, gives rise to œdema pulmonum and dyspnœa. The return of the venous blood from the bronchial

mucous membrane is retarded ; hence there is set up a catarrhal condition there which causes cough and expectoration, and assists in the production of dyspnoea. As we trace back the venous channels, we come to the right side of the heart. It is true that in doing so we have travelled through an artery, the pulmonary, but this (as is well known) carries venous blood. When the right heart contracts to force the blood into the pulmonary artery, it finds more than the normal resistance to the outgoing column of blood, since the left heart is forcing it back as well as forward. This of course prevents the right ventricle from emptying itself as it should, so that when the auricle contracts for the purpose of filling the ventricle, it finds undue resistance because the ventricle, instead of being entirely empty and collapsed, contains a certain amount of blood ; the auricle, therefore, in order to empty itself, must force some of its contents back into the superior and inferior venæ cavæ. This condition of course causes more marked increase of pressure in the vascular territories drained by the inferior cava and its tributaries than in other portions of the system. As a first symptom comes œdema of the feet and ankles. The hepatic veins emptying into the ascending cava, soon feel the retarded flow through that great vein, and the vascular mechanism of the liver is at once deranged. The hepatic veins are formed from the capillaries which come from the breaking up of the portal vein. A stasis in the first, means of necessity stasis in the second, and stasis in the portal vein must be followed by venous stasis in the entire chylipoietic viscera. As a consequence of this, there arises gastric as well as intestinal catarrh ; and nausea, vomiting, pyrosis, meteorism, and constipation alternating with diarrhoea, are legitimate outgrowths of the disabled mitral valve.

The renal veins emptying into the inferior cava feel the check at their outlet, and transmit it back to their radicals in the kidneys. The derangement of the blood pressure in the kidneys soon affects the secretion of urine, which can only be normal under a normal renal blood pressure. It is a well-known physiological fact that if the renal veins be occluded to any considerable extent, albumin will appear in the urine.

Let us see why this occurs. In the glomeruli the watery portion of the urine, together with the urine salts, are separated from the blood, which is brought to them by the renal afferent arteries. At the same time that this takes place, a certain amount of albumin is also thrown out of the blood into the glomeruli. Now, as the

water and solids of the urine pass down through the tubuli uriniferi, the epithelial cells lining these tubes extract from the fluid passing through them the albumin which it contains, and returns it to the blood flowing in the veins which are formed by the renal efferent arteries, and which represent the venous radicals of the renal veins. As I have stated, normal excretion of urine takes place only when the histological elements of the kidneys are in a normal state, and when the vascular pressure in them is normal. The increased pressure in the renal veins and their radicals raises the pressure in them above the point which allows of the albumin being freely absorbed from the tubuli uriniferi. Thus, as a result of cardiac lesion, there is present albuminuria.

The change in the character and amount of the secretions of the gastro-intestinal mucosa interferes with digestion and absorption. Venous stasis means deranged function wherever it occurs. The mesenteric glands fail to act as they should upon the chyle corpuscles, hence the general nutrition begins to fail, and what with the loss of albumin through the urine and the lessened supply, the tendency to œdema increases apace.

If the amount of albumin in the blood is diminished below a certain percentage, serious effusion is sure to take place; hence any cause which tends to reduce the amount of albumin and at the same time decrease the supply, is a powerful factor in the production of œdema or anasarca. When a case of cardiac valvular disease has advanced to that stage wherein most or all of the symptoms enumerated have made their appearance, the physician has many things to take into consideration if he wishes to save his patient from the combined attack of the main army—the valvular disease—and the sharp-shooters and raiders represented by the outlying symptoms.

Strengthening of the heart, compensatory hypertrophy, is the only entrenchment behind which the general organism can successfully defend itself. All efforts must be in the direction of securing this as soon as possible. The venous stasis in the chylopoietic viscera is a sharp-shooter who interferes seriously with the bringing forward of supplies for the sustenance of the heart-muscle which is being fearfully overworked; and the stasis in the kidneys represent raiders, who destroy or steal some of the stores which the army (or heart) held in reserve. The heart, realizing the necessity for restoring the equilibrium of the deranged circulation, is working beyond its strength day and night; without proper reinforcements it cannot long stand the strain to which it

is being subjected. It demands more food, but the source from which it should obtain the increased supply, the blood, contains less than usual, and the trophic centres, whose duty or function it has been to direct the pabulum to the heart, are slow to respond to the new and augmented demand made upon them. The increased activity required of them makes it necessary that they shall be supplied with more nourishment than usual. If they are not strengthened and stimulated, they will not hand out food to the overtaxed heart as fast as it needs it, even though plenty be at their disposal.

Nature is a good fighter, though sometimes a bad general. The heart, in trying to overcome the valvular deficiency by more frequent and powerful contractions, may so exhaust the muscular fibres engaged, that, before recruits have arrived, they will have begun to undergo degeneration, and the reserve arrives too late. Hence the indication is to restrain within proper limits, by appropriate means, the undue and dangerous overaction of the heart. By this means it may not degenerate to such an extent as to make useless the new muscular fibres, which after a time will represent compensatory hypertrophy. The therapeutic accuracy of those who understand the administration of remedies in accordance with the law of similars, enables them to carry such a case through when all other methods fail. But in order to do so, they must understand homœopathy, and not rely upon simply matching symptoms, regardless of how the drug has produced them, or to what cause they are due in the disease being treated. *Tolle causam* is an aphorism which will not bear to be neglected ; at the same time it requires occasionally rare discrimination to not be led astray in attempting to follow this principle. In the case of the disease under consideration, it is clear that in the ordinary sense of the term, the deficient valve is the *fons et origo* of all the other symptoms, and yet remedies directed to this lesion are for the most part entirely out of place. It is problematical whether any remedy can restore a cardiac valve or part thereof which has really been destroyed. At any rate, the act of reparation must be so slow that did not cardiac hypertrophy come to the relief of the patient, he would die from some one, or from a combination of the effects due to the diseased valve. Indeed in all probability the heart, as an organ, would undergo degeneration and dilatation, and hence be unable to keep up the unequal struggle until the renewed valve should take the strain off of it.

Like a good general bringing his troops against the enemy, we

must see that all parts of the line of battle are kept sufficiently strong to resist the enemy, otherwise they may turn our flank or pierce our centre (Napoleon's favorite method), and thus we will lose the fight through weakness at one point, while at all others we were capable of resisting the foe. See that the heart is not overdoing itself beyond the point of repair. In order to do this it must be restrained when necessary, the trophic nerves controlling it must be kept up to their work, the catarrhal condition of the various mucosa must be diminished as much as possible, particularly in the gastro-intestinal tract, in order that digestion and assimilation may be preserved as near to normal as possible; the urea must not be allowed to accumulate to excess in the system, as it tends to lower the general vitality of the tissues, and prevent their proper development—an exceedingly bad complication in such a case. Remember that the valvular lesion itself is only a reflex, an effect of some disturbance (as rheumatism, scarlet fever, etc.) which has invaded the system at some previous time, but which has entirely disappeared, leaving its "reflex" behind. By the same token a permanent hepatic, gastric, renal, bronchial, pulmonary, or other derangement is liable to remain after the cardiac lesion has been practically overcome, if this be too long in being accomplished. A thorough knowledge of disease makes one far more competent to combat it, and yet it almost makes one feel extremely modest in the matter of arraying his therapeutic army against that of disease. Many times the enemy deserts his fortifications and retreats out of the country because he has starved himself out; he has eaten all that is tasteful to or digestible for him. Then it is, often, that General Therapeutics comes on the field, just as the enemy has got into full, voluntary retreat, and claims a great victory.

As has been stated before, the mere giving of some remedy which is indicated by the presence of some fancied "characteristic," will not be sufficient to carry many cases through safely, *i. e.*, to the point of compensatory hypertrophy. The treatment of such a case at times requires careful discrimination as to the selection of remedies, proper foods, time of rest, kind and amount of exercise, etc., all of which are important factors in the treatment of serious cases of cardiac valvular lesions. The treatment therapeutic, hygienic, etc., is too voluminous to deal with in this paper; I will therefore defer it until another time.

INFLAMMATION OF KIDNEYS, ureters, bladder and urethra, with scanty, turbid, dark urine, having epithelial sediment—*Terebinthina*.

SHOCK.

BY F. G. OEHME, M.D., ROSEBURG, OREGON.

THE article on "Surgical Shock," by Dr. Macdonald, in the June, 1893, number of the *HAHNEMANNIAN MONTHLY*, reminds me of two very remarkable cases.

A young man was convalescent from a very severe typhoid fever, and had commenced sitting up. I was sent for in great haste, as he was said to be dying. I reached him quickly, and found him just recovering from a deep fainting spell. His features were sunken and ghastly. While having a natural stool he had fainted, which caused him and his family to think that death was approaching. Thermometry was then in its infancy, and it was not then known that evacuations, especially large ones, in sickness, would frequently produce a rapid sinking of the temperature, thus accounting for faintness or fainting. To guard against a repetition, I ordered three doses of one drop of the tincture of camphor, in quick succession, shortly before an evacuation. There was no recurrence of syncope during stool.

On page 356, the doctor relates: "A few days later, an enema of warm water was given, by a competent nurse, and was promptly followed by profound shock." Did the shock take place right after *taking* the injection, or not until after *passing* it?

A multipara had, within a few days of her confinement, such a tremendous fright, while sitting at dinner, that she jumped up from her chair and fell to the floor in a deep faint. I saw her immediately after. She had not fully recovered, and was in a very nervous condition. I gave opium 3x in water, every few minutes at first, afterwards every hour. She told me that the child within her gave a perfect leap. There were no movements whatever of the child afterwards. The next day liquor amnii, mixed with flakes of meconium, passed frequently, but without real labor pains. The following day she was confined without any irregularity, and there were no ill effects from the fright perceptible on mother or child.

I have used in a forty years' practice camphor as a preventive of shock, and opium against the ill effects of shock or fright in many similar cases, although not so striking and alarming as the two just related.

PRESIDENT'S ANNUAL ADDRESS.

BY JOSEPH C. GUERNSEY, A.M., M.D., PHILADELPHIA.

MEMBERS OF THE HOMŒOPATHIC SOCIETY OF THE STATE OF PENNSYLVANIA :

Before beginning the address which it is my privilege to deliver upon this occasion, I desire to return my sincere thanks for the honor, the highest in your gift, which it has been your will to confer upon me, by electing me as your presiding officer for the twenty-ninth session of your meeting.

The fact that the office came to me wholly unsought, renders it so much the more prized ; for a public office is not only a public trust, but it implies a mark of confidence in and respect for the incumbent.

LADIES AND GENTLEMEN : In his annual address the President of this Society seeks for some new ideas and new topics of interest to present to the profession and laity. I hope to be able in a measure to fill this requirement to-night ; but before proceeding to the new, there are some matters which though they have been presented for our consideration before, must again and yet again be dwelt upon until they can be referred to only as duties done.

MEDICAL EXAMINERS' BILL.

One subject, the one which perhaps of all others demanded our most earnest and immediate attention was the Medical Examiners' Bill. I say *was*, because this burning topic after eight years of struggle and warfare is now at rest. Thanks to the united and determined work of our entire Committee on Legislation, nobly aided by many of our fellow-members from all parts of the State, the legislature at Harrisburg last spring, by an overwhelming majority, passed a Medical Examiners' bill which provides for three separate boards of examiners, each board to consist of seven homœopaths, seven allopaths, and seven eclectics ; thus doing equal justice to the three leading schools of medicine in our State. On the 19th of May, 1893, Governor Pattison signed this bill which thus became a *law*.

LEGAL RIGHTS.

But legislation for the welfare, protection and advancement of our school of medicine is not yet completed. Far from it. We are in

fact only beginning to receive our legal rights and just recognition. Let us consider for a moment what are some of the prerogatives of citizenship to which we are entitled. A few years ago the Committee on "Medical Legislation" of the American Institute of Homœopathy presented a carefully-prepared report* setting forth the rights that ought to be accorded the homœopathic profession; these included: Admission of homœopaths to the Army and Navy Medical Corps, boards of health, marine hospitals, pension examiners, port and quarantine physicians; appointments to hospitals, general and insane, national guards and militia of the State, surgeons-general, both national and State; money appropriations to homœopathic hospitals, dispensaries, etc.; physicians to the poor, vaccine physicians, coroners and coroners' physicians, police district physicians.

Without going into detail I may state that we are to-day in possession of many of these rights; we are represented upon boards of health, we are pension examiners, the surgeon-general of at least one State is a homœopath, money is appropriated for our hospitals and dispensaries by every legislature and we are constantly receiving the minor appointments referred to above. All these facts, together with our success in the Medical Examiners' bill, are foundations to build upon and are indications of what we can and shall receive when we apply for them in the right spirit. By the "right spirit" I mean the harmonious working of our whole school in persistent, insistent, and consistent demands for our rights as a school of medicine which is second to none in the world in medical attainments, in general education and in social standing. We demand our full share in all the duties, rights and privileges assigned to or accorded any other school of medicine. Immediate attention should be given to our medical management of an insane asylum in our State, and our admission as medical practitioners to the Army and Navy Medical Corps.

ADMISSION OF HOMŒOPATHS TO THE ARMY AND NAVY.

It is hard to discuss this latter point calmly in face of the gross injustice that has been done us, and those who believe in and desire our method of cure; and in face of a medical bigotry as intolerant as the religious bigotry of mediæval times.

No fair-minded man or woman can deny the RIGHT of every sick and suffering mortal to claim that method of cure which he or she

* See *Trans. Amer. Inst. Hom.*, 1882, p. 61.

believes to be the best. This is no more to be denied than the right of any person to choose which church to attend—or whether to take tea and coffee with sugar or without!

We of the homœopathic profession are perfect types of “good citizens.” We obey the laws; we bring up our children in the love of God, and in the respect of man; we pay our taxes, a large proportion of which goes to support hospitals and almshouses—in the medical management of which we have no voice; and when ruthless war broke upon this fair land we fought to preserve the unity of our country and the inestimable boon of freedom won by our patriotic forefathers; freedom to assess our own taxes; freedom to make our own laws and the right to choose those who shall administer these laws; freedom to express and to hold our individual opinions, on matters temporal and spiritual, medical and scientific; freedom of the press; freedom to worship God according to the dictates of one’s own conscience; *and for freedom* to four millions of the colored race, from the shackles of slavery. But what was their reward when, having endured all other hardships, our brave soldiers became sick or wounded?

Did they have the justice due the poorest outcast, in this *free* (?) country, viz., of calling a physician of their choice? No! they were forcibly taken to a hospital and compelled to receive a form of medical treatment which they distrusted and abhorred. They were allowed to call a priest or clergyman, of any denomination they desired, for spiritual consolation. But they were then, and are to day, denied the right to summon a physician whose medical tenets harmonized with their own. In the dark days of religious intolerance things were no worse than this; and let us remember that this state of things exists to-day. If war should again break out there is *but ONE system of medical practice, recognized by law* in the army and navy; and every sick or wounded soldier and sailor and woman nurse, would be denied the freedom of choosing a medical attendant. Tell me whether there can be a grosser example of taxation without representation!

Now comes the most pertinent question—Who is to blame for such a state of affairs, and why does it exist? In my judgment, we homœopaths are most largely to blame because we have not been sufficiently aggressive in demanding our rights, and not sufficiently determined that we **WILL HAVE THEM!** We have shown in Pennsylvania, and in some other States, that we are strong enough by persistent and harmonious working to obtain just legislation in

our behalf; and events have recently proved that we have powerful political friends who are ready to join with us in urging our admission as physicians and surgeons to the Army and Navy Medical Corps.

I have asked the above in the name of justice to the sick and wounded, and to homœopathy. But here is another reason. It would give our school a chance to obtain statistics for comparison with the results obtained by the old school—both working under the same conditions and on the same class of patients. Then might it be shown which one has the lowest mortality and which carries its patients through to recovery in the shortest time. We claim that we can take men sick with pneumonia, typhoid fever, dysentery—or any disease incident to camp-life, and by our system of treatment, restore them to the ranks fit for duty, in a shorter time and in better physical condition, than can the allopaths. So I say let us obtain the right to prove these claims of ours by comparative statistics. But yet this is not the whole of the matter. Rivalry, or competition, is often productive of great gain to the parties interested. Thus it would undoubtedly be here. When the allopaths found us working side by side with them they would strive to obtain better results than they now do with no emulation. Sad, yes horrible, stories have come to us from the battle-field of criminal carelessness in treatment of the wounded—of hastily chopping off arms and legs that might with a little care have been saved; and of most inefficient treatment of the sick in hospitals where, no matter what the ailment, nothing else but routine treatment in all cases prevailed. To summarize, we find four reasons why homœopathy should be fully recognized and legally established in the Army and Navy Medical Corps.

1. It would be an act of justice to our school, and to those who desire our method of treatment.

2. It would be but a fair representation in return for our taxation.

3. It would enable us to obtain valuable statistics of the results of homœopathy compared with allopathy.

4. Under the spirit of rivalry, the two systems of practice mutually striving for the best results, the sick and wounded would receive more considerate care than they now do.

Homœopaths are not kept out of the Army and Navy Medical Corps because they are deficient in medical attainments. Experience has proved the contrary. Many of our brethren during the Civil War passed the necessary examination and were admitted—but they had to conceal the fact that they were homœopaths.

This whole matter was ably discussed in the Annual Address* of Dr. John C. Morgan, when President of this Society, and an admirable *résumé* of the rights due the homœopathic school of medicine, together with proposed legal enactments to assist in procuring them, was presented in a report † to the American Institute of Homœopathy, 1882.

NO DENTISTS OR OCULISTS IN THE ARMY.

Before leaving the subject of medical matters in the army and navy, I must say that the United States government fails to provide justly for other needs of her soldiers and sailors. How many dentists and oculists do you suppose are in the Army Medical Corps? In reply to a query of mine on this subject, addressed to the Surgeon-General of the United States Army, I received the following reply:

WAR DEPARTMENT, WASHINGTON, January 19, 1893.

“J.C. GUERNSEY, M.D., Sir: Acknowledging the receipt of your communication of the 18th inst., I am instructed by the Surgeon-General to inform you that there are no dentists or oculists in the military service of the United States especially recognized as such by the government.

Very respectfully,

CHARLES R. GREENLEAF, Lieutenant-Colonel,
Deputy Surgeon-General United States Army.”

Not only are there no dentists or oculists in the United States Army, but evidently no knowledge of such specialties is required. I have in my possession “Specimens of Written Questions” contained in the “Circular of Information for Medical Men who may be Desirous of Entering the United States Army Medical Department,” issued from the Surgeon-General’s Office, Washington, March 4, 1891; and the same issued February 1, 1893. These questions comprise arithmetic, geography, history and literature, chemistry, physics, anatomy, physiology, surgery, hygiene, pathology and bacteriology, therapeutics, materia medica, and toxicology, practice of medicine, obstetrics and diseases of women and children. But not one question is propounded which seems to require any knowledge of the care and treatment of the eyes or teeth! Although good teeth are one of the requisites for admission to the army and

* *Transactions of this Society*, 1882, pp. 10, *et seq.*

† *Transactions of American Institute of Homœopathy*, 1882, pp. 61 to 81 inclusive.

navy it seems that once in the ranks our soldiers and sailors are left, without skilled dental help, to suffer with a hundred preventable ills. This is all wrong. There should be a sufficient number of dentists in the army and navy ranking at least as assistant surgeons in pay and privileges, who should be assigned to a certain number of posts, and their time of travel from one to the other so arranged that every man in the service could have his teeth examined and put in order certainly once a year—or better still, once every six months. Good eyes and clear eye-sight are most essential to soldiers and sailors; oculists are therefore as useful as dentists. I would like to see each class of specialists, as well as homœopathic physicians and surgeons, assigned to the Army and Navy Medical Corps.

COMPENSATION TO THE ARMY MEDICAL CORPS.

As the pay and emoluments from service in the Army Medical Corps may be an incentive to our young men to strive for appointments therein, I will mention that the Medical Corps of the army consists of a surgeon-general, with the rank of brigadier-general; six assistant surgeons-general, with the rank of colonel; ten deputy surgeons-general, with the rank of lieutenant-colonel; fifty surgeons, with the rank of major, and one hundred and twenty-five assistant-surgeons, with the rank of first lieutenant, mounted for the first five years, and the rank of captain, mounted, thereafter until promoted to major. To each rank is attached a fixed annual salary; an assistant-surgeon (the lowest), with the rank of first lieutenant, mounted, receives \$1600 per annum. At the end of five years he is promoted to captain, and receives \$2000 per year, which, with the increase of ten per cent. for five years' service, is \$2200. And so the pay is generously increased with each promotion. Officers *i.e.*, surgeons), in addition to their pay proper, are furnished with a liberal allowance of quarters according to rank. Mounted officers, including all officers of the medical corps, are provided with forage, stabling and transportation for two horses. Books and instruments are supplied in abundance for the use of medical officers in the performance of their duties. A medical officer, upon appointment, is usually assigned for some months as junior at a large military post, in order that he may become acquainted with army regulations before he is thrown upon his own responsibility. His stations after that are likely to alternate between the frontier and more desirable points. Leave of absence on full pay is allowed at the rate of one month per year. Absence from duty on account of sickness involves no

loss of pay. After a few years' service, leave to visit centres of medical and surgical science for purposes of study is usually looked upon with favor, and like indulgences to travel abroad may be granted when the exigencies of the service permit.* The army medical officer need not vegetate. Assignments for duty are made to the large cities so that he can come in contact with the leading medical men in civil life, and see what is being done by the most advanced workers. These details are made for one year only so that as many medical officers as possible may become familiar with the practice of the leading physicians and surgeons in this country, may attend medical lectures, meetings of medical societies, etc. The life of an army surgeon is not hard, while his opportunities for study and for gaining distinction are great. There are at present five vacancies in the corps and five more will occur within a year.†

Surely there are sufficient inducements to incline many of our best men to strive for so honorable an appointment. The medical examinations are searching, but they do *not* include anything that cannot be learned in our own medical colleges.

SPENDING THE NATION'S MONEY.

There was recently held in Washington what purported to be a Pan-American Medical Congress. At the opening session of this Congress the Chairman of the Committee of Arrangements announced the order of entertainments for the Congress, and in doing so gave credit to Senator Gorman for securing the appropriation by which it was made possible for the committee to extend the hospitality of the country to the delegates to the Congress.

After the close of the business session of the Congress the delegates were taken to Baltimore, Philadelphia, New York, Boston, Saratoga, Niagara Falls, Detroit, Cincinnati, and Chicago—the trip covering the period from September 8th to September 19th.

This interested me so much that I sent to Washington for full information. I learned that by a *Public Resolution*, No. 19, approved July 18, 1892, the President of the United States was "authorized and requested to invite the several governments of the Republics of Mexico, Central and South America, Hayti and Santo Domingo, and the kingdom of Hawaii, to send official delegates to the meeting of the Pan-American Medical Congress," etc. Also from a copy of the

* For full information concerning admission to the Army Medical Corps address the Surgeon-General, U. S. Army, Washington, D. C.

† *Medical Record*, August 5, 1893, p. 179.

Sundry Civil Appropriation Bill of 1892, page 21, "To meet the expenses of entertaining the foreign delegates who have been invited to attend said Congress . . . *fifteen thousand dollars.*" *This was not a Pan-American Medical Congress*, because although boards of health having homœopathists as members were invited, no homœopathic physicians, as physicians, were invited. Our school contributes its full share to the nation's money, and we have as much right to a share of it spent in this way as the allopaths. In his official address the president of this "*Pan-American Medical Congress*" stated that the meeting was but a preliminary of the merging of the Congress with the American Medical Association. So we must do—call a meeting of the Pan-American *Homœopathic Congress*, and merge it into the American Institute of Homœopathy. And then it will be in order for a senator to "secure an appropriation for our committee of arrangements to extend the hospitalities of the country to our delegates."

HOMŒOPATHS IN INSANE ASYLUMS.

Our *right* as a school of medicine to have a fair representation in the management of insane asylums, almshouses, and indeed all municipal charities, and to practice therein, is as paramount as the right of any other school of medicine in the world; and whatever argument can be advanced showing the right of others to so practice, applies equally to us. As an act of justice, we demand all the rights accorded the dominant school; as a reward for fidelity to our professional duties, and to our high medical standing, we claim all the privileges enjoyed by it; and as a part of our duties as American citizens, we ask to share any burdens laid upon it. We contribute our full share of taxation in supporting these institutions, and we should receive our *full* share of representation in return. Behold how small our representation in the matter of insane hospitals. Out of this whole world, and all the countries therein, all insane hospitals are under allopathic management excepting only four. These four are found in the United States, *viz.*, New York, at Middletown; Massachusetts, at Westborough; Minnesota, at Fergus Falls; California, at San Bernardino. Michigan also, at Ionia, has a State insane asylum under homœopathic control, but it is not required by charter as are the four above. The State of Connecticut is supporting one by private enterprise. We were to have had one in New Jersey, but after the bill had passed

both houses of the legislature, the governor refused to sign it.* Strenuous efforts have been made in nine other States to have insane asylums placed by legislative action under Homœopathic treatment; these are Pennsylvania, Maine, Oregon, Kansas, Kentucky, Wyoming, Texas, Illinois, and New Jersey as referred to above. Of these States Pennsylvania ranks first in importance and strong homœopathic influence both from the size of our clientele and the number of our physicians. We have in Pennsylvania five large hospitals for the treatment of the insane—at Norristown, Harrisburg, Danville, Warren, Dixmont, and the very large insane department of the Philadelphia Almshouse—all of them charitable institutions supported by our State and to a large degree by our own money which we pay in taxes; but every one of them is absolutely under allopathic control and treatment. Though taxed for the support of *all* of these, we are not allowed any representation in even one of them. What rank injustice this is!

There is another asylum about to be built at Wernersville, Pennsylvania. The trustees for this have not yet been appointed by the Legislature; their appointment will fix the management, *i.e.*, the treatment. Although this asylum is to be for chronic and supposed incurable cases, yet we should certainly strive to have it placed under our care: and we can no doubt gain legal control, if we unitedly and harmoniously seek it. As soon as the legislators become acquainted with the justice of our demands, and learn the gratifying results of our system of treatment, they will grant to US our RIGHTS, and to OUR PATIENTS the PRIVILEGE of choosing their medical treatment. Very complete and convincing statistics of the superiority of homœopathic treatment over that of the old-school methods, have been made. They can be found in an admirable and comprehensive brochure entitled *Homœopathy and the Insane*, by N. Emmons Paine, M.D., of West Newton, Mass., in which he gives a very interesting and complete account of the existing status of homœopathy in relation to insane asylums, public and private; also carefully prepared statistical tables of cure. Besides these, we have those presented by Drs. Hugh Pitcairn, Bingham and Parsons in their Presidential addresses.†

There are three factors requisite to procure the representation of homœopathy, on a full legal basis, in the army and navy, in insane asylums, municipal general hospitals, etc. These are:

* See *Medical Century*, August, 1893, p. 276.

† See our *Transactions*, 1888, pp. 15 *et seq.*; 1890, p. 13; 1892, p. 25.

1. Complete organization of the homœopathic profession, *and our friends*, so that we may act in perfect unity.

2. The public must be kept informed through the newspapers of the advantage and justice of what we want, and its assistance and sympathy be enlisted.

3. *Nil Desperandum!* must be our motto. No matter how often or how strenuously we are opposed, we must fight the good fight until the victory is won.

NEED OF ORGANIZATION.

The value of perfect organization in all bodies, ecclesiastical, political and medical, striving to attain certain ends, is so great that it cannot be overestimated. Upon our organization will the progress of homœopathy depend. With our forces massed and fully instructed as to just what we want to obtain and just how we are to go about it; thoroughly disciplined to obey the orders of their leaders, *i.e.*, the chairmen of the various committees, we would present a more formidable front to our opponents; and by concerted action be the better able to secure the rights which certainly belong to us. But with our forces scattered and unorganized we can expect to do little or nothing. In fact the greatest bar to our success is found in our own ranks. It is indifference or worse, still, *selfishness*. Too many of our number think and strive only for their own personal interest, forgetting that in the welfare of the whole profession, lies the good and prosperity of each individual member. Homœopathy would not be occupying so much space in the background to-day, if every one of her adherents had done his duty. On the contrary, we would be fairly represented in the Army and Navy Medical Corps; in the management of insane asylums, almshouses and all municipal charities.

The truth is that the present status of homœopathy has been gained by a comparatively few of our number who have devoted their time, their energy, their brains, and their money to the furtherance of the cause they espoused when they received their diplomas on graduation day. But homœopathy is in no danger; she can take care of herself; it is the majority of homœopaths who have all this time laid back, reaping the harvest of seed sown by others—and even grumbling and finding fault with those doing the work because more was not accomplished. If so much has been accomplished by a comparatively few, how infinitely much more could have been gained if we had all arisen in our might and labored together to build up our school and obtain our rights. All sorts of excuses are

made for this laziness and indifference to the interests of our school. A principal one is, "I am not fitted for such work; I do not know how to go about it." This is no excuse. No one knows how to do any kind of work—until he learns how. The heart must be in the right place first; there must be the will and desire to help on homœopathy and the *savoir faire* will soon come.

I wish to urge upon the members of this Society, and indeed upon all homœopaths, the necessity of taking a more active and conspicuous part in all municipal, and public, and social affairs. If there is a public speech to be made; or a notable office of trust to be filled; or a special lecture on a medical topic to be delivered let a homœopath volunteer to perform the task, or let things be so arranged that he shall receive the appointment.

It has become a custom in many of our large cities during the winter season to have courses of lectures, free, upon hygiene or general sanitation, dietetics, the care of the eyes, throat, etc., and upon medical, though non-sectarian, topics generally. (There are two such courses delivered every winter in the auditorium of the Young Men's Christian Association in Philadelphia.) We must see to it that in the future the members of this Society have their share of such lectures to deliver. We need to be more aggressive and more self-assertive for our welfare; we must obtain recognition by the community as a body of intelligent, active and public spirited men and women. And why should we not take this stand and be thus recognized? Taken man for man, and woman for woman, the homœopathic profession is fully equal in education, social standing and medical attainments to man-doctor with man-doctor, and woman-doctor with woman-doctor, with the *old* school, or *any other* school of medicine in the world.

HOMŒOPATHY IN THE RED CROSS SOCIETY.

It is a matter of surprise and regret that more attention has not been given to the representation of homœopathy in the Society of the Red Cross, than which, perhaps, no more powerful and useful association exists. It is a confederation of relief societies in different countries, and carries on its work under the sign of the Red Cross, out of compliment to the Swiss Republic, where the first convention was held. This organization is only called out in emergency and time of great need. Its aim is to relieve the suffering of soldiers in time of war; to afford *immediate* help in time of national or widespread calamities, such as a pestilence of cholera, yellow

fever, and the like ; devastation caused by famine, fire or flood ; railway disasters, mining catastrophes, etc. Money accruing to the Society from dues and contributions is used for the purchase of stores of every sort, which are kept on hand as a permanent relief fund, so that in sudden calamities active and prompt relief may be afforded suffering humanity.

Many of the managers of the Red Cross are such strong believers in homœopathy that they will have no other medical treatment. Wishing to have an official declaration of the status of homœopathy in the society itself I wrote to its President as follows :

PHILA., August 31, 1893.

MISS CLARA BARTON :

Dear Madam.—Will you please tell me whether there are any homœopathic physicians or surgeons connected with the Society of the Red Cross in this country. If there are none at present, will the names of such be placed upon your medical staff and their services accepted when needed, if tendered on the same conditions as the physicians and surgeons now enrolled for duty in the Red Cross.

Very truly yours,

J. C. GUERNSEY.

Miss Barton's courteous reply was non-committal ; she did not say positively whether our services as a school would be accepted or declined. I think we ought to have a clear understanding and know certainly *whether our treatment will be allowed to those desiring it*. If so, we can speedily form a Red Cross Medical Corps from our ranks ready to march at a moment's notice and render efficient help in any emergency.

HAHNEMANN'S STATUE.

The fund now being collected to erect a monument to the memory of the founder of homœopathy also demands our earnest attention. To a Pennsylvania colleague, Dr. James H. McClelland, belongs the credit of suggesting this project. In his presidential address, delivered before this Society in 1881, he predicted that "at some day in the not distant future . . . the statue unveiled will be that of SAMUEL HAHNEMANN." At the meeting of the American Institute of Homœopathy, in June, 1892, it was unanimously determined to erect in the city of Washington a national monument to the memory of Samuel Hahnemann. The plans look to a heroic statue in

bronze, upon a granite pedestal—a grand work of art, requiring a fund of at least \$50,000. As committees were being appointed in the various states of the Union to solicit subscriptions, I appointed one for this purpose in our own State. This committee promptly organized and sent out an appropriate circular requesting contributions to the fund. Local committees have also been appointed in Philadelphia, Pittsburgh and other cities, and the work has been vigorously pushed forward. Up to date the amount subscribed by Pennsylvania was about \$2629.

Considering the time we have been at work, the result is encouraging. Subscriptions to this fund should be made by every homœopathic physician in the state; every patient treated homœopathically should be given the privilege of subscribing *by their physicians!* The various well-known means of raising money should be called into operation, as fairs, tableaux, theatricals, and the like. One plan which is already yielding good results is the placing of dime banks in the hands of children. This was a good move, as the little ones evince an amount of interest and energy in their collections that might well be emulated by their elders.

OFFICINAL GARDENS.

There is another subject in the accomplishment of which I seek to enlist your interest and ask your co-operation. It is the establishment of "Officinal Gardens," which shall be stocked with the flowers and plants having medicinal value. Space for these gardens could be obtained in the parks of our large cities. The advantages of such gardens from an educational point of view to the profession, and the laity as well, are too obvious to require elaboration at this time. Many physicians would be glad to assist for the sake of the practical instruction they would obtain in becoming familiar with officinal plants; and botany is such a popular study with the laity that recruits from that source would be numerous, and a few moderate subscriptions from some wealthy patrons of horticulture would help on the work amazingly. These gardens should be commenced in a modest way, using mainly indigenous and hardy plants; with a few desirable exotics, which could be carried through the winter in the greenhouses of the parks. As is well-known, horticulturists are famed for being most liberal in assisting each other; so we might expect many donations of desirable plants. Ultimately, the cost of maintaining a garden completely stocked with foreign, as well as native, plants need not be unattainable by us. By that time

a gardener or curator would be required to properly classify the plants, besides caring for and protecting them; a moderate sized greenhouse fitted with heating apparatus; a pond and small marsh for the aquatic plants and those of moist habitat; two or three hundred dollars yearly for new stock, glass and incidentals. If a few members of this Society, living in the cities, feel enough interest in this project to go actively to work, we can have gardens in a few years that will be most instructive and pleasurable. The marked interest taken in this topic may be inferred from the fact that at the only general session of the recent Pan-American Medical Congress, where all the members from the various sections were present, a paper was read on the relation of the flora of the American Continent to the practice of medicine.

"THE MEDICAL PROFESSION AND THE COLLEGE GRADUATE,"

Is the title of an article recently published in a current periodical.* The author writes as follows:

"In examining the class statistics given in the commencement numbers of the college magazines, one is surprised to see that only one in twenty is put down for medicine under the head of "Chosen Calling." In the report of the Secretary of the American Academy of Medicine it is stated that only about 5 per cent. of the physicians practicing in the United States are graduates of colleges. This is a very unaccountable condition of affairs. The medical schools on the continent of Europe are departments in the universities. In every instance the equivalent of the Bachelor's degree is required for admission to the study of medicine, and yet the medical students number almost one-fourth the total enrollment of the university. *In other words, almost 25 per cent. of the educated men on the continent of Europe look to the profession of medicine as an occupation, while in the United States not more than 5 per cent. of our college-bred men enter upon medical studies.* This neglect of medicine for theology, law, journalism and business is hard to explain. Theology does not offer as great financial reward, either to mediocrity or to superlative excellence, as medicine; but the study of theology is encouraged systematically by a great many institutions; and many so-called scholarships are provided which cannot be found in medicine. . . . The law offers less to relative mediocrity and very much more to superiority than medicine does. But the struggle in law is longer

* *The University Magazine*, New York, October, 1892.

for the average man, and the prizes, though many times larger, are fewer; and the effect of the struggle on character-building is less uniformly desirable than in medicine. . . . In the professions of mining and engineering, the reward of mediocrity is *less* than in any of the professions, except that of the ministry. . . . Journalism has nothing but bondage for mediocrity. It is of all the professions the most uncertain in its rewards, both financial and honorary. . . . Medicine, alone, presents an opportunity for a studious, beneficent and independent existence. It gives a certain though moderate competence. The position of the physician allows him the very best opportunities for the study of all social problems. He has the confidence of all classes of men. He enters in the same intimate and affectionate manner into the sufferings of the poor and the burdens of the rich. . . . Unfortunate conditions in the medical schools, and in the unorganized medical profession, divert many of the best-educated and most desirable men from this useful and independent calling."

The foregoing article, from which I have given extracts, set me to thinking, How shall many of the best educated and most desirable men (college-bred) be drawn to the study and practice of medicine? To my mind, the answer suggests itself in what I read above, to wit, "the study of theology is encouraged systematically by a great many institutions, and many so-called scholarships are provided, which cannot be found in medicine." Here, then, is the answer: *let these scholarships be found in medicine!* Let each one of our homœopathic medical colleges offer annually one or more scholarships, to be awarded students desiring them by a competitive examination on such subjects as shall be mutually agreed upon by the faculties of the medical college offering the scholarship, and the college accepting the same.

Which of our homœopathic colleges will be the first to do this? Princeton, Yale, Harvard, Cornell, Columbia, Williams, and nearly all the colleges, hold their commencements in June. It would be a good plan to have the names of the successful candidates gaining these scholarships announced as prize-winners from the commencement stage; they could enter upon the study of medicine the ensuing autumn. I cannot but feel that such a procedure, if adopted by medical colleges, *i.e.*, the giving of a free medical education as a scholarship, would bring into our ranks many of "the best educated and most desirable" college-bred men.

In the *Public Ledger*, of Philadelphia, July 3, 1893, is the fol-

lowing item *àpropos* to this subject: "James Gordon Bennett has established in Harvard, Yale, Princeton, and Columbia colleges, the University of New York, and the College of the City of New York, annual prizes intended to encourage young men to prepare themselves for the profession of journalism. In each institution the prize will consist of the interest on \$1000. The competition for the prize is to be in the form of essays in English prose."

FELLOW-MEMBERS: In this Address I have purposely abstained from all mention of homœopathic dogmas and theories. As honest investigators laboring for the development of our science it is not, in my opinion, the function of the President of this society to dictate what dogma shall prevail, or to decide which theory is correct. Ample opportunity for all such expressions of individual opinion is afforded in the papers presented by us to the various bureaus.

It would be a good thing for this Society, and would contribute immeasurably to the promulgation and improvement of homœopathy, if *every one* of our members had something given him or her to do. It seems to be an unwritten law with us that no one not placed upon a bureau or a committee is expected to prepare and present a paper at our meetings or do any Society work. This is a mistake. Many a report of a most interesting case, or a brilliant clinical observation, or the valuable confirmation of a rare drug symptom, are lost to us because one thinks: "As I am not on a bureau, I am not expected to write." This is entirely a false assumption. The Homœopathic Medical Society of the State of Pennsylvania expects a tribute of affection and a contribution to her existence from *every one of her children*. I shall therefore be peculiarly indebted to each member of this Society who will say to me in person or by mail: "I feel interested in this or that bureau, and, if appointed, will write a paper for it." Also to all who will say: "I am willing to work on the Committee of Legislation; to raise funds for the statue of Hahnemann; to eliminate the debt from our Society; to establish a botanical garden of officinal plants; to show by statistics the superiority of homœopathy in the treatment of insanity, cholera, and other diseases; to introduce homœopathic physicians and surgeons into the Army and Navy Medical Corps, the Red Cross, and similar relief societies." In short, whoever will may come and contribute their services to the advancement of our cause.

EDITORIAL.

THE UNITY OF CAUSE IN DISEASE.

PERHAPS nowhere does Nature seem to show a greater intolerance of restraint, and impatience of artificial limitations than in the domain of medical science; nowhere does she seem to take greater delight in overturning theories, breaking down generalizations, and trying to prove rules by creating innumerable exceptions.

How rarely do we find typical cases of disease! A most carefully collected complex of symptoms duly labelled and baptized is sent forth as a new entity, only to be modified either by enlargement or restriction by subsequent investigation, until finally what seemed to be characteristic and typical becomes secondary and fortuitous, while originally unimportant, or even unknown concomitants come to constitute the essence of the disease.

In spite of this, however, such schemata must be made, such generalizations must be sought. Science is nothing but systematized knowledge, and the infinity of observations would ever remain an infinite jumble, were the effort not constantly being made to reduce it to order—to higher and higher unities.

The frequent mistakes of which Nature convicts us are due in a great measure, of course, to imperfect observation and to too hasty generalization, but very largely too to the use of a false standard in judging of the relative value of observed phenomena. The terms *great* and *small*, *important* and *insignificant* are finite comparative terms. In the infinite domain of nature there is nothing small or insignificant, because there is nothing great; everything is of equal importance could we but see into the very essence of things.

These thoughts have been suggested by the perusal of an address by Dr. D. Drummond before the British Medical Association in August, on "Causal Relations in Disease," in which he advocates the unity of cause in some of the well-known diseases.

With his plea that "the persistent attempt to reduce morbid conditions to a single cause will have a material and beneficial bearing upon the method of treatment," and, that "such recognition will also be a diagnostic help," we agree perfectly, but in the rather violent application of the law of induction to gain this unity, we cannot join him. In his "Illustrations of Unal Causality" he presents loco-

motor ataxy as invariably the result of antecedent syphilis, and asserts "where you find the former you may declare with a feeling of absolute certainty that there has been at a previous date the latter, to which this locomotor ataxy is due."

He questions the statement of Gowers that "in less than 10 per cent. of the whole number syphilis can be excluded with certainty." Even with reference to the 10 per cent.—and here we take issue with him—their indications are to be disregarded and the inductive force of the 90 per cent. is to be conclusive.

Again in general paralysis of the insane he quotes with approval the statistics of Jacobson that at least 65 per cent. of the cases are specific, and, applying the inductive method, shows how the result could be a means of making a reliable diagnosis "if we can say with confidence that in eliminating syphilis in a mental case we are practically excluding general paralysis."

Based on the frequent connection between aneurism and syphilis he has "found it a good practical rule not to diagnose aneurism in a doubtful case in the absence of syphilis—presupposing an accurate history of the case."

So also in the causal relation of pneumonia to empyema, rheumatism to chorea, rheumatism, gout, etc., to various cardiac lesions, he is inclined to apply strictly the inductive method, and according to it "to conclude that what is true of certain individuals of a class is true of the whole of the class."

While this method may have been as he asserts, "medicine's best friend and its glory," it is only, we think, by furnishing us with working hypotheses.

The fact that they are merely hypotheses, and that in framing them a certain percentage of observations has been disregarded must ever be kept in mind, or the very errors will result against which the reasoning is to guard us. If, for example, taking the case of locomotor ataxy, we find 90 per cent. consequent on syphilis and from that conclude that the remaining 10 per cent. must have had the same antecedent, it at once puts an end to all doubt and scrutiny; whereas if this fact leads us to argue that the 10 per cent. of cases, because of their difference in causation, must also differ *per se* in some way, anatomically or otherwise, investigation is stimulated anew, and further differentiation may take place, whereby hitherto neglected or overlooked symptoms and conditions receive their proper consideration. The doubt stimulates inquiry and conduces to greater precision.

To the homœopath such a closer study of disease entities becomes easier by reason of his peculiar *materia medica*, *provided* it be not a meaningless conglomeration of symptoms and key-notes but a picture, the main strokes of which are noted and their signification recognized.

By a comparison of several drug pictures most nearly resembling a special disease picture he will be led to trace minute differences and to appreciate their importance in arriving at a differential diagnosis. He will be led to discover pathological relationships hitherto undreamed of. While therefore higher generalizations and the highest unity should be our aim, a unity gained by the sacrifice of what may prove important elements, is attended by just as much danger to scientific progress as is a failure to rise above the stage of inchoate details.

SPEAKING of the seeming vagaries and inconsistencies of nature we commend to our readers as a shining example of the same, Mr. Earnest Hart, editor of the *British Medical Journal*. He must have been called into being in one of nature's most sportive moods, and hence—*lucus a non lucendo*—is called Earnest, and Hart because he is *not* a hart but ———.

The journal edited by him is a noble one, a monument of which any one might be proud. The leaders are well written and indicative of intellectual and scientific attainments, and yet this editor from whom so much was to be expected, comes over to Milwaukee and before the Association of Medical Editors reads a paper on the Code, in which he says that "the treatment instituted by homœopaths as such, is absolutely ineffective," and "does not and cannot be of any avail whatever." He is willing "to regard homœopathy as an honest delusion (in which the patient undoubtedly shares), that treatment by infinitesimals may be of some benefit, but the physician should not by his presence ratify such delusion." "Consultation with a homœopath from this point of view is worse than a sham, worse than an imposture. It is a crime."

The majority of the profession in America, as events will show, are in favor of so modifying the Code as to admit of consultations between any legally qualified physicians. The three-board medical examiners' bills will place all physicians on the same level as to general medical attainments, and the difference in the matter of treatment between a homœopathic and an allopathic physician, would no doubt in many cases be no greater than that between two

allopaths, say one of the expectant school and one of the old foggy calomel and jalap kind. As the question was one that was expected to occupy the attention of the American Medical Association, Mr. Hart was, of course, at liberty to express his views, although the good taste of commenting upon a subject which so peculiarly depends upon circumstances of which he could be but poorly informed, can well be doubted.

When, however, on being allowed by courtesy to take part in the deliberations of the Pan-American Congress at Washington, and on being called upon for a paper, he gives the same diatribe, we are at a loss which to wonder at most, his poverty of invention, his poor taste, or his blooming ignorance. Even the non-medical press recognized how he has abused the courtesy extended to him, and the applause from the small audience was given rather to the man than to his utterances.

We are unable to build up in our minds a concept that shall duly represent this big little Earnest Hart, and therefore gladly relegate him to innocuous desuetude.

NURSES.

THE intense struggle for existence which but a few years ago fell almost exclusively to the lot of the male wage-earner, in the last years has demanded recruits from both sexes and all ages. Woman has demanded her rights, and has gained the right to earn her bread in the sweat of her brow. She has entered, in almost all fields, in direct competition with her brother, and rightly. Sex seems in many cases an accident; let each individual spirit find its own mode of utterance, its own work to do. Hence we are not of those who look upon this or that occupation as unbecoming for a woman. For this one or that one it might indeed be, but for the person that voluntarily undertakes it, for her it is the outcome of her own individuality, and hence most becoming. We, however, as all others, have our little preferences, and regard some occupations as more fitting for the ostensible female than others. For instance, there would have to be a wide-spread and very fatal epidemic among lawyers before we would entrust anything in that line to a female esquire; while we would most willingly entrust our comfort and perhaps even our life to the skilled sympathy of one of the present race of trained nurses. The ghoulish race of Sairy Gamps is fortunately almost

extinct, and yet some few of her qualities occasionally re-appear, by a sort of reversion of type, in numbers of the later species, and have caused in some quarters unwarranted prejudice against the whole class.

While woman, as woman, is peculiarly adapted to fill the position of nurse, there are certain qualifications that she must possess if she would be a good nurse. First and foremost we would place a sound physical constitution, able to stand the wear and tear of her profession, and forming a necessary basis for all the other traits, individual and spiritual, which are equally as requisite. How can she be patient with her charge if her own liver be out of order? How avoid at least thinking naughty words on being called up unnecessarily twenty times a night, if she has a sick-headache or a weak back? An attack of indigestion would make an angel sulk, much more a woman. She must have an equable temper, ready tact, quickness of comprehension, and above all a sympathetic nature. We do not mean by this last a weak yielding to the whims and caprices of the patient, but a nature that lends to each action the charm of disinterestedness, and raises its possessor above all considerations of filthy lucre. We have seen nurses give drink to their charges as sympathetically as a town-pump, from a tin dipper, and others, again, whose very presence seemed to soothe and to refresh.

We, as physicians, know better than any others when we meet a born nurse—for nurses, like poets, are born, not made—and, for the good of humanity, we should feel urged to encourage such an one to recognize her calling.

It is an arduous profession, full of trials, crosses, and disappointments, but one which has, also, its very bright sides. It is, perhaps, of all occupations engaged in by women at the present time, the most remunerative. The faithful performance of duty here, perhaps as nowhere else, is ultimately rewarded by recognition and gratitude, both nearly as soothing, if not as substantial, as the weekly honorarium.

The necessity for having nurses in sympathy with our own mode of treatment was early felt, and we have now schools for their training in connection with our hospitals in Boston, Rochester, Brooklyn, Wilmington, Washington, Baltimore, Pittsburgh, and Philadelphia, and perhaps elsewhere. These are doing an excellent work in trying to meet the constantly increasing demand for skilled homœopathic nurses.

Their profession being in accordance with the laws, and, therefore

also, with the will of nature, is specially protected by her, and its overcrowding and consequent undervaluation prevented by a most beneficent but most curious provision. She has implanted in the breast of the average man, a peculiar susceptibility to the charming presence of the uniformed nurse. Whether it be owing to her jaunty cap, or to her coquettish apron, or even to her trim blue dress, or to all combined, we know not, but her numbers are rapidly depleted by marriage; and from being a general practitioner, she soon becomes a specialist, while her translation makes room for others.

SIGMOIDITIS AND ITS TREATMENT.—Dr. Mayor, of Geneva, has observed a series of cases during the last six years, which demonstrate the existence of an inflammation of the sigmoid flexure, very analogous to the classic symptoms of appendicitis and peri-typhilitis. Habitual constipation is the chief cause, from mechanical irritation and possible introduction of septic germs. The inflammation may be limited to the mucous coat, or extend to the surrounding peritonæum, peri-sigmoiditis. The principal symptom is a painful tumor in the left iliac fossæ, palpable in the less severe forms. It may be confounded with the sigmoidal cord of Glenard, in enteroptosis, phlegmon and iliac adenitis, simple gastro-colic dilatation, and muco-membranous colitis. Glenard's cord gives a more resistant sensation of a cylindrical body of greater hardness; iliac adenitis has dulness at summit of the tumor, while in sigmoiditis the tumor is sonorous. Iliac phlegmon tends to invade below the pubic arch. Gastro-colic dilatation has simultaneous gastrectasia. Muco-membranous colitis is associated with hysteria and neurasthenia; the sigmoid flexure is hard and painful, but not inflamed. The characteristic stools will differentiate ribbon-like bands. In sigmoiditis fever may be present or not. The patients are often emaciated, have a coated tongue, anorexia and irregular and hard stools. All his patients recovered, though in cases the affection may be long lasting; in one the peri-sigmoiditis led to formation of an abscess, with evacuation of its contents into the intestines as a creamy stool. As treatment, he employs liquid diet, milk, bouillon, purges, a dose of castor oil now and then, injections, and poultices to the abdomen.—*La Semaine Médicale*, No. 46, 1893.

ARSENICAL AND SATURNINE PARALYSIS.—Dr. Jolly states the differential diagnosis of these two kinds of paralysis to present but few difficulties in most cases. Lead paralysis is easily recognized by its attacking the extensors of the forearms from where it extends to the small muscles of the hands. From there it jumps to the upper arm and only first after this initial attack are the other muscle groups affected. Sensation suffers but rarely. On the contrary, arsenic seems to affect chiefly the lower extremities, attacks but rarely and to a slight degree the arms and what is characteristic, while the motility suffers the sensation also is influenced, simultaneously. Arsenical paralysis is assumed to depend upon a peripheral neuritis. Its pathological anatomy is not well understood, for now-a-days when the manufacture of wall-papers, etc., is carefully controlled it appears less and less frequently and again it generally ends in recovery. Lead, one of the principal metallic poisons, and a large number of necropsies are on record yet there is not much agreement with regard to the nature of the paralysis. Most of the older writers refer its seat to the gray matter of the spinal cord, a view advocated at present by Erb, while the greater number of the younger investigators claim a peripheral degeneration of the nerves to be the cause of the weakened motility. Jolly is inclined to hold to the latter opinion. He has recently observed a case where the patient had a characteristic lead paralysis and suddenly died in status epilepticus. In spite of a series of sections of the spinal cord being made with great care not the slightest abnormal change could be discovered. The circumstance that a lead paralysis is sometimes curable would point to the probable peripheral nature of the disease for were a polio-myelitis the cause a restoration to the normal would hardly be expected.—*Norsk Magazin for Lægevidenskaben*, No. 66, 1893.

GLEANINGS.

GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D., AND FRANK H. PRITCHARD, M.D.

TREATMENT OF FUNCTIONAL DISEASES OF THE HEART.—Prof. Constantin Paul divides them into cardiac neurasthenia, palpitation of the growing period (adulthood), palpitation of the menopause, *mal de theatre* (theatre disease), and the palpitation of dyspepsia.

Cardiac Neurasthenia.—A condition due to overwork, brain-fag, and appearing as violent palpitations from slight emotions. Neither the seaboard nor the mountains agree with these patients, rather shaded and airy valleys. Hydrotherapy is the sovereign remedy. Neither river baths, cold baths, nor steam baths are tolerated, but baths of 28–30 Cent. of five minutes' duration, and followed by a vigorous rubbing and a walk or slight exercise without effort. Massage is preferable. Electricity is of no value. They should eat slowly, but little at a time, and increase the number of meals. Farinaceous and starchy foods in small quantities, white meats to be eaten for a long time. Alcohol and tobacco, as well as after-dinner rest, are to be forbidden.

Palpitations of the Growing Period.—Young and growing boys and girls are often affected with palpitation, due apparently to too rapid growth. There is no hypertrophy present, as some writers have asserted. Advise rest of mind and body, interrupt their studies, and send them into the country upon a farm, where, after a year, they will easily make up for the loss of time.

Palpitations of the Menopause.—A transitory disturbance. If there be anæmia, then give the arseniate of iron, 1–4 mgms. per diem; if there, on the contrary, be plethora, then administer the tincture of hamamelis, 25 drops twice a day, or lithine, or the phosphate of soda.

Palpitations in Dyspepsia.—These patients complain of a pain in the cardiac region, a sensation as if their hearts "were beating in water," of depression and palpitation, yet, on careful questioning, it will be found that there is no dyspnoea on making an effort, ascending stairs, walking fast or lifting a weight—no dyspnoea of effort. They do not think that they suffer from dyspepsia, pretend that their digestion is good, have a good appetite, are plump and are not constipated. This is a salivary dyspepsia. They have bad teeth or eat fast, masticate insufficiently, and mix the saliva but imperfectly with their food. They are very thirsty and drink a good deal, are prone to over-indulge in bread and farinaceous foods, which require much liquid, so that at the end of the meal they have to unbutton their vests. Pyrosis often is present, eructations of lactic and butyric acid, somnolence, after eating. At night their digestion torments them; towards two or three in the morning they awaken and urinate. Sometimes there is an actual indigestion with nocturnal vomiting. When the stomach is enormously distended, their cardiac troubles come on with palpitation, intermittence. The fainting spells sometimes observed are not indicative of any gravity. Regulate the mastication; if they have no teeth, have them obtain a set of artificial ones. For those that eat alone, have them read during their meals. Bitter drugs are of service—gentian—wine of gentian. After meals let them take extract of malt and a powder of prepared chalk in doses of 1 gm. Avoid bread and farinaceous foods. Thickened soups, milk foods, eggs, white meats, even red meats and salads, greens and both raw and cooked fruits. He should drink but little, and only during the second half of the repast. His wine should be thinned with water or mineral waters. No coffee, very little tea, and but little tobacco. Alcohol in very small quantities and thinned with water. An infusion of aromatic plants will replace coffee advantageously at the end of the meal and prevent putrid dyspepsia—peppermint, thyme, winter-green. Country air, rest and physical exercise are of value.

Mal de Theatre.—There is a theatre sickness, as well as there is a sea sickness. Towards nine o'clock, at the commencement of the second act, the physician is often called in great haste to a person, generally a lady, who has fainted. It is generally found to be some one from the provinces, who, having arrived in the city, eats supper rapidly in a restaurant and hurries into an overheated theatre. Young women in the first months of pregnancy are especially liable to this accident. Cerebral anæmia is the cause, and which should not be confounded with hysteric syncope, epileptic coma nor with a simulated attack of hysteria. Horizontal position, fresh air. Do not permit them to rise for ten to fifteen minutes — *La Tribune Médicale*, No. 26, 1893.

PSEUDO-DIPHTHERITIC ANGINA OF PNEUMOCOCCIC ORIGIN—Prof. Jaccoud, of Paris, calls attention to a form of pseudo-membranous angina greatly resembling diphtheria, but which differs in being of pneumococcic origin. It begins suddenly with a chill, sometimes severe fever, depression so that the patient is forced to go to bed, and agitation. The pain in the throat does not appear for fifteen, twenty-four or thirty-six hours. The tonsils are found red and swollen, with possibly a violet-red spot on one. The membranes do not appear for twenty-four hours, and then the white spots rapidly coalesce. The fever, varying in intensity, is always present, and attains its maximum the first or second day, which it holds during the entire course. Glandular enlargement may be present. The false membranes first appearing around the crypts spread, and, by uniting, form extensively over the tonsils, fauces and pharynx. They are grayish-white, more or less dense, uniform, homogeneous, very adherent. Histologically the membranes resemble those of diphtheria. They do not extend upwards nor downwards as in diphtheria, the fever soon falls. A week may be said to be the duration of the disease. The sudden beginning reminds one of a pneumonia, while in diphtheria *the beginning is slow*, has *no initial chill*, and the highest thermic point is *not* reached the first or second day. He prescribes milk in large quantities, salicylic acid in doses of one to two grammes daily as long as the fever persists, when the dose is reduced. Alcohol is given to those having a tendency to adynamia. Remove the membranes and treat the denuded mucous membrane antiseptically, preferably with sublimate (1 to 2 per cent.). If they return, remove them again. Use a spray of boric acid and keep the surrounding air antiseptic. Make a bacteriological examination, if possible, and when certain that it is not diphtheria, one may relax the rigorous treatment somewhat, but it is best to treat it from the beginning as were it diphtheria — *La Semaine Médicale*, No. 44, 1893.

ULCERATIVE GONORRHOIC ENDOCARDITIS.—Prof. Leyden reports the case of a young man who entered the hospital and died with aortic insufficiency. The endocarditis was peculiar by the intensity of the fever, the general symptoms, the rapid decrease in the patient's strength, and its malignant character. The patient had shortly before had gonorrhœa with gonorrhœal rheumatism. Two theories are advanced: That the gonococcus is the cause of the inflammation, or that it produces a septic condition followed by deposition of other cocci. — *Muenchener Medicinische Wochenschrift*, No. 28, 1893.

BRIGHT'S DISEASE.—Dr. Dieulafoy, of Paris, calls attention to the fact that two of the most important symptoms of Bright's disease (albuminuria and œdema) are often not present. In sixty cases observed by him, these symptoms were lacking in a fourth of them. Not rarely, albuminuria may be absent for a long time. In such cases one finds more or less pronounced uræmic symptoms, slight signs of Bright's disease, and often no trace of albumin. On the other hand, it is known that persons often have albumin in their urine, but though the albuminuria is persistent, they never have any uræmic symptoms, for they have no actual renal disease. Without regarding the inconstant albuminuria, Bright's disease may be diagnosticated by the following signs:

- (1) Disturbances of hearing, which are more frequent than of vision, with roaring in the ears, difficult hearing, and rarely deafness.
- (2) Meniere's vertigo, which only yields to milk diet.
- (3) The sensation of the finger being dead, which lasts from a minute to a quarter of an hour.
- (4) Very obstinate itching.
- (5) Frequent inclination to pass water, pollakuria, which is often confounded

with polyuria, for there are patients who pass much and often, and others who urinate often and but little at a time.

(6) A symptom to which he has before called attention, is the peculiar sensitiveness of Bright's disease patients to the cold, and which he has denominated kryesthesia. It is chiefly noticed in the lower extremities, knees, calves, and feet.

(7) Tortuosity of the temporal arteries, which are hard, and appear like an atheromatous artery. It is not atheromatous, for the tortuosity is caused by the increased blood pressure often seen in the whole circulatory system of such subjects.

(8) Painful and nocturnal cramps in the calves of the legs, long-lasting hæmorrhages, electric shocks, i.e., the patient goes to sleep, or when already fallen asleep, suddenly awakens with a jerk that may be compared with an electric discharge. It is a short uræmic convulsion.

In absence of albuminuria and œdema, these symptoms are sufficient to diagnose Bright's disease, though separately they are of little value.—*Wiener Medizinische Presse*, No. 31, 1893.

INTERLOBAR PLEURITIS.—Dr. D. E. Gerhardt, of Strasburg, finds the disease to begin suddenly or gradually with very violent pain in the side and dyspnoea. Fever is either present from the beginning or soon sets in and is usually quite high. Still the temperature may vary, but elevation is attended with chilliness. Examination of the lungs in a number of cases reveals nothing abnormal, at the most but a few rattling râles and a slight increase, or even decrease, of the vesicular breathing on the affected side. In other cases there is a strip of dulness, of two or three centimeters' breadth, running from the region of the third or fourth dorsal vertebrae obliquely outwards and downwards, and reaching the lower border of the lung before intersecting the axillary line. The findings in the posterior axillary line are especially characteristic, where both above and below the dulness, loud resonance is to be heard. Reduction of the vocal fremitus and respiratory sound, and possible pleuritic friction, render the diagnosis more certain; yet the signs of exudation need not be pronounced, even with the typical dulness. In a period varying from fourteen to eighty days, the expectoration, which has been scanty and mucous or muco-purulent, suddenly becomes very profuse, often pure pus, which is sometimes foetid. At the same time the fever disappears, and the patient feels relieved. The profuse expectoration lasts for some time, in favorable cases ending in a few days, and the patient may be said to be cured in two or three weeks. In other cases this stage persists for weeks and even months, yet recovery here is apparently the rule. In a few and rare cases death takes place from severe septicæmia. The effusion is apparently purulent from the start, and frequently foetid. Adhesions of great extent are generally found in the fatal cases, which lead one to think that it follows a general pleuritis, and this focus, occupying the interlobar slit, looms up as a primary empyema, though in many cases there is no history of such a preceding pleuritis—which then must have run without the patient's knowledge, and suddenly become purulent. The patients are generally weak and reduced individuals. In seeking the exudate, use long needles for puncture. Perform thoracocentesis only in those cases where improvement delays for weeks or months. If the pus be superficial, operate; in case it be deep and only reached by long needles, then wait, and eventually open with the thermocautery.—*Berliner Klinische Wochenschrift*, No. 33, 1893.

PSEUDO-MEMBRANOUS ENTERITIS.—Dr. Rothman has investigated this subject, and finds but few cases in the literature, and those to be chiefly observed in women, associated with constipation. The discharges were isolated from the fæces and found to consist chiefly of mucus and not of fibrin. The disease is either of purely nervous origin or complicated with an inflammation of the intestines. From microscopic examination it was seen that the mucous plugs were continued into the outlets of the gland ducts. The sections were colored with thionin, which colors mucin very well. Hence the affection has its seat in the colon, and is due to a secretion of mucus from the glands. The irritation is caused by the constipation, and the ribbon-like bands consist of mucin, while the inflammatory symptoms are of secondary nature.—*Muenchener Medicinische Wochenschrift*, No. 24, 1893.

GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D.

FILLING OF OSSEOUS CAVITIES WITH PLASTER-OF-PARIS, COPPER AMALGAM, CEMENT, ETC.—Dr. Dreesmann, at the suggestion of Prof. Trendelenburg, has attempted to fill osseous cavities with some firm material as plaster-of-Paris, and describes two cases where he carried out this procedure. The first was a four-year old girl with caries of the tibia in which, after removal of the carious spot, a cavity of the size of hazelnut remained, which was completely filled with plaster prepared by mixing it with a 5 per cent solution of carbolic acid. The skin was then sutured over the cavity, and, in three weeks, healing was complete. The same result was obtained in a twelve-year old boy with two necrotic cavities in the ulna, from the size of a hazelnut to that of a cherry. In a case of caries of the tarsus the same procedure was attempted, but the result was not as good, as the condition of the bones was not as favorable. This method should be of service in osseous defects after the extraction of sequestra in osteal tuberculosis, osteomyelitis, bone tumors, etc. To disinfect the cavity completely he fills it with olive oil, introduces a glowing thermocautery and lets it boil a short time. Filling a cavity has many advantages; it shortens the time of healing, makes healing by first intention possible, the cicatrix is much more slightly, smooth, not adherent to the bone, and there is no sinking in of the bone and skin with the process of healing. Suppuration and possible recurrence are avoided. The chief difficulty lies in removing all the affected bone and thorough disinfection of the field. All foci should be sought out by the concave mirror. It is contraindicated in osteomyelitis without demarcation of affected tissue, in osteal tuberculosis in connection with articular disease as well as in extensive suppuration and fistula formation with undermining of the skin. Also if the cavity is apparently too large for the bone substance to sustain the limb.—*Deutsche Medicinische Wochenschrift*.

Maier has used copper amalgam to line such cavities and then fills them with cement.—*Wiener Medizinische Presse*.

Sonnenburg (Berlin) has experimented on the same line, filling large bone cavities in dogs and smaller ones in human subjects. He employs an amalgam of copper with cement which healed in such cavities without producing any irritation or any disagreeable effects.—*Ibid*.

IMPLANTATION OF DECALCIFIED BONE.—LeDentu cites the following case as an example of the value of decalcified bone in the treatment of tuberculosis of the tarsus:

A twenty-one-year-old girl presented extensive destruction of the os calcis, astragalus and several other tarsal bones, the disease being so deeply seated that amputation was about to be performed. He extirpated the whole os calcis, astragalus and scaphoid bone, and curetted the cuboid. Without hoping for success he placed two large pieces of decalcified bone into the cavity, the one crosswise corresponding to the anterior portion of the foot, and the other larger one in the direction of the calcaneum. The soft parts were curetted and the wound sutured with drainage. Four months later there was complete recovery, and she went about with a silicate-of-soda bandage. In twenty months the foot was firm and solid, and the functions of the newly-formed tibio-tarsal joint were satisfactory.—*Norsk Magazin for Lægevidenskaben*.

A NEW USE FOR SALOL IN SURGERY.—Reynier and Isch-Wall, finding that salol liquefies at a low temperature, and remains in a liquid form for fifteen to twenty minutes, have associated it with iodoform or aristol. They do not form chemical combinations, but recrystallize on cooling. They have found these mixtures of advantage in the disinfection of irregularly shaped cavities where asepsis is frequently so difficult to obtain. In opened and evacuated cold abscesses the pure salol or that mixed with iodoform when injected solidifies in cooling and forms a compact mass, which, acting slowly upon the surrounding tissues, finally produces complete asepsis of the cavity. In unopened cold abscesses they have also obtained excellent results with one or two punctures through which salol was injected. It has also been found of service in fistulous tracts with or without connection with an

osseous lesion. Thus they obtained a cure in two patients with obstinate fistulæ, after resection of the ribs, for tuberculous lesions, in which the ordinary therapeutic measures had failed. Finally, it is in the treatment of osseous cavities of large size that the best results were obtained. They cite one patient with suppurating tuberculous inflammation of the trochanter where one injection of liquid salol, distending the whole cavity, was followed by recovery without suppuration. The same result was gotten in a patient with osteomyelitis of the upper extremity of the tibia. A mixture of iodoform and salol applied to a fresh wound forms a sort of aseptic varnish and renders other dressings unnecessary.—*La Semaine Médicale*.

TREATMENT OF SOFT CHANCRES.—Cavazzini has used the following combination with gratifying results, healing taking place in from one to three weeks and buboes being rarely observed:

Chloral hydrate, one part; camphor, one part; glycerine, five parts.—*Deutsche Medizinische Wochenschrift*.

TO STOP HÆMORRHAGE IN HÆMOPHILIA.—Mantenffel (Dorpat, Russia), was consulted by a dentist in the case of a young and weakly boy of twelve years who had bled for two days continuously after the extraction of a lower molar tooth. As the ordinary methods of hæmostasis had been used in vain, he injected a solution of cocaine into the gum, preparatory to cauterizing with the thermo-cautery, when the bleeding ceased and did not reappear for several hours. By repeating the injection a few times the hæmorrhage was definitely controlled.—*Deutsche Medizinische Wochenschrift*.

CHLOROFORM AND NASAL IRRITATION.—Guerin (Paris) long since observed that inhalations of chloroform by the nose were more dangerous than by the mouth, for the irritation of the mucous membrane may, by a reflex action, produce fatal syncope. Laborde experimented with a chloroformed rabbit which had been tracheotomized, and a tracheal canula inserted. If it received chloroform by the canula the heart-beat was not modified; but if, on the contrary, this was given by the nose, the beat became irregular, weak, and slow. When the anæsthesia was profound, the result upon the heart was less marked. Lefort observed several years ago a case demonstrating the influence of the nasal reflex upon the heart. A boy of ten years was about to be operated on for syndactylia, and in inhaling the chloroform he breathed very slowly. On being told to breathe faster, he took a long inspiration through the nose, and suddenly died. All attempts to revive him were in vain. This excitation of the nasal reflex at the beginning of chloroformization is very dangerous. Many surgeons now take the precaution to compress the nostrils at the beginning of chloroformization, to avoid this danger.—*Le Progrès Médical*.

DIET AND TREATMENT AFTER OPERATIONS.—Lucas-Championnière (Paris) calls attention to the increased excretion of urea after operations, of which the explanation and source are difficult; some holding that it is due to absorption of the dead tissues involved in the operation; others that the chloroform, acting on the liver, influences the production of urea in some manner. The practical results are that care is to be exercised, after operation, in the regulation of the diet, and that purgatives are to be employed. He cites the case of a vigorous young man, who, after a fracture of the patella, was operated on and the fragments sutured. He was the over-fed son of a gouty father, and excreted 45 grammes of urea daily before the operation. The reparative changes in the wound went on with marvellous rapidity, but the patient suffered from uninterrupted vomiting during the twenty-one days following the operation, which ended with his death. The patellar wound had entirely healed. In such subjects, he believes that before performing an operation they should be submitted to a preliminary treatment, the essentials of which would be diet, alteratives and purgatives. Nicaise also endorses the early employment of purgatives in patients after operations. He would not permit a patient to be placed upon a solid diet before the third day. Verneuil claims that chloroform is a contra-indication to feeding patients well immediately after an operation. For the first twenty-four hours he does not give his patients anything; then he administers liquid food in moderate quantities, and adds to their dietary progressively during the days following.—*La Semaine Médicale*.

GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D. AND J. NICHOLAS MITCHELL, M.D.

TRANSACTIONS OF THE FIFTH GERMAN CONGRESS FOR GYNÆCOLOGY.—
THE TREATMENT OF PYOSALPINX.—A. Martin states that he is no longer a warm advocate for drainage as formerly, as it causes an unjustifiable complication. The value of adnexa operations can only be determined ultimately by great research. Judgment on permanent results required yet more time. The so-called “uneventful recoveries” are not always the most successful. In his last twenty cases of enucleation of fibroid tumors, he lost only one. He has abandoned constriction of the uterus with the rubber tube. Instead of this, he has his assistant compress the collum of the uterus against the symphysis pubis, while he introduces near together numbers of *étage* layers of continuous catgut sutures.

Olshausen states that in operating for pyosalpinx, he begins the separation at the fundus uteri, as rupture of the tube is most likely to occur in the cul-de-sac of Douglas, and it does not then occur till the close of the operation. He elevates the patient at an angle of 70–80°, though he does not think so much elevation essential.

Fraenkel exposes the pus sac, aspirates it, and then peels it out, with careful protection of the intestines.

Sänger declares himself in favor of drainage, especially if dangerous infection is probably present and there are large bleeding surfaces. He also drains after operating for pelvic abscess. He drains after the method of Mikulicz, and operates with pelvis elevated high up, after Trendelenburg’s method. He carefully surrounds the site of operation with gauze before peeling out the tube.

Rosthorn gives the following indications for adnexa operations: 1. Presence of a distinct tumor. 2. A clear history of recurrent inflammatory processes. 3. Severe complaints, local or general, making the patient unable to work, with failure of all therapeutic resources. 4. Severe atypical hæmorrhage. The complaints after operations, due to the so-called “exudations” about the stumps, are to be ascribed to local infection from the tubal secretions. It often requires months of care and treatment for the exudate to disappear.—*Centralblatt für Gynäkologie*, No. 24, 1893.

DISEASE OF THE KIDNEYS AS A COMPLICATION TO CANCER UTERI.—Dr. Currier in a discussion before the New York Obstetrical Society, quoted Lanqureaux as stating that as a result of extensive studies in the dead-house on those having died of uterine cancer, that advanced carcinoma of the uterus was invariably associated with severe disease of the kidneys.

The speaker said that he had himself made quite a number of post-mortem examinations on women who had died of advanced uterine cancer, and had found this statement true in every case which he had thus examined. He believed, therefore, that in these cases a radical operation offered but little prospect of lasting benefit, nevertheless he thought it good practice in every case of carcinoma of the uterus to remove the uterus, where this could be done.—*The New York Journal of Gynecology and Obstetrics*, 1893.

THE DIAGNOSIS OF TUBAL PREGNANCY.—Abel is of the opinion that the chief difference between the cast-off decidua of extra-uterine pregnancy and a menstrual decidua lies in the absence of the glands in the former. In the decidua after abortion, the glands show unmistakable alterations. They are dilated, possess very irregular forms, the epithelium is broad, the nucleus is only stained with difficulty and more similar to pavement epithelium than the cylindrical. Abel has examined three deciduæ cast-off spontaneously and is of the opinion that when the decidua comes away of itself it consists of only the cellular layer of the uterus and contains no glands. Klein is of the opinion that in tubal pregnancy the presence of the glands in the cast-off decidua is an important characteristic which Abel thinks requires further information. Abel advises against curetting the uterus as it often precipitates rupture of the sac and the curette removing a portion of the glandular layer destroys the specimen for microscopic diagnosis.—*Archiv für Gynäkologie*, Bd. 44, H. i., p. 84, 1893.

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

THE ANTAGONISM OF ATROPINE AND MORPHINE.—J Samelsohn, in a reprint from the *Centralb. f. Klin. Medicine*, '893, No. 11, points with surprise to the fact that medical writers are still debating the question whether morphine acts as an antagonist to atropine. His own experience of the value of morphine in cases of atropine poisoning has completely answered this question long ago.

During the course of twenty-six years Samelsohn met with nine cases of severe atropine poisoning, which represents a proportion of about one in 10,000 patients. It is somewhat surprising, in view of the very frequent use—and as the author holds, the very frequent abuse—of atropine ophthalmic practice, that serious toxic symptoms should occur so seldom. Six of the nine cases were in children, and were mostly due to the unskillful use of the remedy, the drops finding their way into the mouth instead of into the eyes. The toxic symptoms were those ordinarily produced, viz., extreme excitement of the vascular system, great restlessness often passing on to delirium, and in some instances, general convulsions. In every case a morphine injection promptly brought the alarming symptoms to an end.

Since adopting the practice of prescribing atropine for children only in the form of an ointment, Samelsohn has seen no further case of poisoning, even in the mildest degree. He adds, however, that a case in which a woman gave her child an ointment—happily not an atropine ointment—to eat, has warned him that even this method is not absolutely free from risk.

The dose of morphine injected in nearly all of Samelsohn's cases of atropine poisoning was 0.02 g. (nearly $\frac{1}{2}$ of a grain).

PREVENTION OF DEAFNESS.—The first warnings of the trouble are as follows: Frequently recurring colds in the head, annoying noises in the ears, an acute ear-ache followed by a discharge which does not appear inclined to cease, thick voice, faulty articulation combined with mouth-breathing and annoying obstructions of the nostrils; all of these symptoms, if persistent, endanger the hearing and should receive serious consideration.

It should be remembered that there is always a time when these incurable diseases of the middle ear are readily curable; but during this time these patients are usually waiting to see if they will not recover from natural causes. Let the profession agree upon and teach a correct and uniform method of treatment for middle ear diseases; teach the laity and the profession the necessity of giving threatening symptoms prompt attention and effective treatment, and the following generation will not be affected with deafness.

CHANCER OF THE EYELIDS.—In the course of a clinical lecture at the Hotel-Dieu, Professor Panas thus described the characteristics of a chancre of the eyelid: The ulcer is seldom excavated. Its base seems to be on a level with the surrounding healthy parts. It is covered with small crusts. When these are detached there is seen a smooth surface of a raw-ham color. It generally occupies the internal palpebral commissure, whence it spreads symmetrically to the inner fourth of the upper and lower lids. If it is pinched up between the index finger and thumb its base is felt to be hard. The sensation is of parchment induration. It has also been compared to the feel of the external ear when taken between the fingers. The glands in front of the ear are enlarged, and this is a characteristic sign, for the afferent lymphatics of these glands come from the eyelid and conjunctiva. The swelling may attain the size of an almond. Other glands, as the sub-maxillary, the facial, and, in fact, all which receive vessels from the inner part of the eyelid, augment in size.

In any case and in any region of the body where lymphatic glands suddenly increase in volume and there exists in the region from which its vessels come an ulcer, think of a chancre; for an epithelioma takes at least six months and sometimes ten years before it involves the glands. Again, the adenopathy of syphilis presents all the characters of the inguino-crural adenopathy which accompanies the genital chancre. The ganglia are hard, round, smooth and painless. They cause no reaction on the part of the skin. The swelling consists of several neighboring glands.—*La Tribune Médicale*.

MONTHLY RETROSPECT OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D., AND FRANK H. PRITCHARD, M.D.

TARANTULA CUBENSIS.—Dr. F. Cartier, in a study of this spider's venom, presents the following therapeutic applications:

Anthrax—*Tarantula cub.* is indicated in the local and general symptoms. Cutting, knife-like pain, constrictive sensation, immobility of the region affected. The writer has used it in six cases with good results. In some cases no other remedy has been given throughout the entire course of the disease. The seat of the disease varies. It is stated to be a specific in any case, whether a black central core has formed or not. No matter how extensive the affection, for Dr. Navaro cured a case in a woman reaching from the neck to her mid-dorsal region and four inches in breadth, with exposure of the dorsal-vertebræ. After the fourth dose the pain ceased and the case went on to recovery in seven weeks. Fever, insomnia, prostration and diarrhœa are the chief symptoms. The fever is intermittent with evening aggravation.

Furuncle.—Though it has been given with success in a few cases, it is not preferable to the other remedies.

Abscess and Phlegmon.—In circumscribed and diffuse phlegmonous inflammations analogous to anthrax, septic wounds of bad nature, septic or poisoned wounds, it has given good results.

Diphtheria.—It has been employed in diphtheria with success, and is recommended as acting as well in this febrile affection as aconite in synochial fever. The initial general symptoms correspond to those of belladonna: redness of the face, biting heat, pulsations of the carotids, agitation and spasms, with symptoms of blood-poisoning. *Tarantula*, *apis* and *crotalus* are the drugs which alter the source of life in altering the composition of the blood or affecting the nerve-centres. The onset is sudden and violent, the fever intense, the thirst pronounced, dysphagia, great sensitiveness of the throat, and the two sides are affected simultaneously. It is of no service after the appearance of the characteristic odor and false membranes. Here the iodide of mercury is the remedy.—*L'Art Medical*, No. 7, 1893.

NEW PROVINGS OF SILICA.—Dr. W. Sorge, of Berlin, has undertaken the re-proving of silica on account of the unreliability of the original provings, and convinced that this remedy must contain pronounced therapeutic properties. From quite a number of provings on various experimenters he resumes the gist as follows:

Silica causes sensitiveness and depression of mind, great sleepiness, but restless sleep; headache, which is either pressive or stitching, often one-sided, more often on the left than the right side, accompanied often by congestion of blood to the head, vertigo and confusion; In connection with great weariness of the whole body, as well as single limbs, so that walking is difficult or the right hand is incapable of writing. These hint of its possible usefulness in hemiplegia, brain affections, migraine, neuralgias of the trigeminus.

Eyes.—Obscure vision, foggiess, photophobia, etc., were usually seen, together with head symptoms, and were to be explained by the cerebral congestion. The affection of the inner eye and conjunctiva were thought not so dependent. Hence one is justified in trying it in cataract, neuritis and chronic conjunctivitis.

Ear.—Difficult vision, lasting for several hours or days, with ringing and roaring in the ears, atrophic catarrh of the tympanic cavity. The nostrils are occluded. Epistaxis and chronic cold point to chronic catarrh of the nasal mucous membrane and to its possible serviceability in ozena and mucous polypi.

Teeth.—Affections of the roots of the teeth. The teeth are apparently loose. Dr. Becker has employed it in many cases of looseness of the teeth, with success.

Cough.—The cough is dry or with mucons or lumpy expectoration, even mixed with bloody streaks and associated with pain in the chest and sensations of constrictions, with rawness in the throat and hoarseness. These symptoms were remarked in several provers, and indicate its possible usefulness in laryngeal and thoracic affections, especially as it caused fever now and then.

Heart.—Palpitation and stitches in the region of the heart.

Urinary Organs.—Pain on urination, lasting for days, with reddish and sand-like sediment in the urine. Paracelsus regarded the remedy as very useful in renal affections and stone in the bladder. One of the provers who suffered from renal stones was obliged to suspend the provings, as his old trouble returned. Frequent and long-lasting pains in the joints and bones, which were tearing, rheumatic and gouty, make the reported cures by Windelband and others probable. It promises much in chronic rheumatism, especially of the joints and bones.

Skin.—This is an important sphere of silica.

He adds to his earlier reports of cases cured that of a fistula in an elderly man, with a tuberculous testicle, with silica. He has recently seen a great improvement in a case of chronic keratitis, with many corneal opacities, from the use of the first dil. of silicated alcohol. Chronic rheumatism of the knee-joint in a teacher was greatly improved by silica in the same dose. One of the provers was subject to a rheumatic pain in the right radius, which disappeared during the proving, to return after it was discontinued. His dry catarrh of the tympanum was ameliorated during the proving.—*Zeitschrift des Berliner Vereines Homœopathischer Aerzte*, Bd. XII., Hft. III. and IV.

TREATMENT OF DYSPEPSIA.—Dr. Tessier considered the treatment of dyspepsia in a paper read before the French Homœopathic Association:

Pulsatilla.—One of the most ancient remedies in homœopathy. Intolerance for fatty foods, pastry and pork; aggravation in the evening and amelioration from the cool air. White and humid tongue, moist. Thirstlessness, insipid, tasteless, pasty or herby taste in the mouth. Repugnance for foods, nausea, and with chilliness and pale face. Sensitiveness of the epigastrium to the least contact. Abundant bilious or mucous diarrhœa.

Bryonia.—A very efficacious remedy, indicated by ardent thirst, dryness of the throat, regurgitation of food and water-brash, vomiting, sensation of a stone in the stomach, obstinate constipation, great burning headache, pain and sharp stitches in the sides. Analogous to *nux vom.*

Cocculus.—An analogue of *nux vom.*, but more nervous and less inflammatory. It is of service when the stomach pains are cramp-like, accompanied by abdominal colic and a sort of drunkenness, with sensation of emptiness in the head, attacks of nausea even to loss of consciousness (*nux moschata*), nausea on arising from the horizontal position, accumulation of saliva.

Chamomile.—Indicated in very impressionable and nervous persons. It acts especially well in the dyspeptic troubles of dentition, especially with a tendency to diarrhœa. Heat and sweatiness of the face after eating. The somnolence during the day may even become so aggravated that the patient falls asleep during the meal, with more or less complete insomnia during the night, with agitation and anxiety.

Calcarea Carbonica.—Bulimia, weakness of digestion, insufficient assimilation, acid regurgitations. Impossibility of having the clothing tightly fitting around the waist. Lymphatic temperament. Pale complexion and thick cellular tissues.

Gratiola.—This drug has rendered him incomparable service in afflux of blood to the head, with heat and somnolence. Great distension of the stomach, lassitude, somnolence after eating. Constriction of the throat, repugnance to water, constipation and constriction of the rectum.

Lycopodium.—Indicated by constipation, pyrosis, flatulence, nocturnal thirst, anorexia alternating with bulimia. Excessive desire for sweets.

Natrum Muriaticum.—Though but little employed, it succeeds when there is chilliness, continual thirst and constipation. Hypochondria. Emaciation, loss of strength and bulimia.

Metallum Album.—This drug is useful in the gravest cases, with fever, emaciation, burning in the stomach, vomiting of food, bile, blood or blackish substances. Intense thirst, which is not satisfied, and adynamia. With it actual resurrections have been made.

Phosphorus, sepia, veratrum, graphites, bismuth, belladonna, and especially atropine, may also be mentioned.

Dr. Marc Jousset has treated cases of flatulent dyspepsia with better success by the alternation of several remedies than by a single one, giving them systematically, according to Dr. Martiny's method. When there is constipation he alternates, calcarea, lycopodium, and carbo vegetabilis, one day the one and the other day the other. With a tendency to diarrhoea he alternates calcarea, mercurius 30x and china 6x.

Dr. Boyer alternates conium and natrum mur. when there are severe pains in the stomach three hours after eating, sometimes insufferable hunger relieved for a time by eating something, enlargement of the liver.

Dr. Love finds a dose of nux vom. before the meal and one of graphites after when the pain sets in immediately after the meal, of service.

Dr. V. L. Simon mentions bismuth when there is a prominent pain element. He treated a case in a business man who from sleepless nights, sedentary life, abuse of tobacco, and mental overwork, suffered from dyspepsia and gastralgia, after several remedies were given in vain was cured by a few doses of bismuth.

Dr. Cartier claims capsicum to be indicated in old dyspeptics who cannot eat without their food being well peppered.—*Revue Homœopathique Française*, No. 7, 1893.

DOLICHOS PRURIENS IN PRURITUS OF LIVER DISEASES.—Dr. Jean de Wée, of Brussels, Belgium, has treated several cases of icterus with intense itching which, in certain organic affections of the liver is very disagreeable, disturbing the patient continually and being often for weeks the sole symptom of which they complain. Homœopathic remedies were found inactive. Mercurius was efficacious in nine cases out of ten where the itching was aggravated by the warmth of the bed. He had two patients where dolichos succeeded: An old lady, with a tumor of the liver whose pruritus was of eight weeks duration and constituted an actual torture. Dolichos gave her relief in two hours. The second, one of congestion of the liver from gall-stones, with icterus, was accompanied, at each congestive attack by intolerable pruritus. It yielded as if by magic to dolichos while in the other attacks it would last as long as the congestion itself, i.e., from five days to two weeks. The indications are vague. The dose was five drops of the mother tincture in the first case and five drops of the third dilution in the second, to be taken during the course of the day. He treated a case of catarrhal jaundice with this drug and completely failed, while carduus marianus relieved it in three days. There was no concomitant icterus.—*Revue Homœopathique Belge*, Année 19, No. 12, 1893.

CHRONIC ENTERITIS.—Dr. Baldelli, of Florence, was consulted by the parents of a child of nine years who had for three years suffered from chronic intestinal catarrh and been under the treatment of various physicians in vain, and finally told that she would probably outgrow it. The child had from five to eight passages in twenty-four hours, of liquid consistency and of a yellowish gray color, containing indigested substances, mucus and blood. Before each stool there were abdominal crampy pains. A few doses of merc. corrosivus were prescribed in varying dilutions, the mucus and blood disappeared from the stools and then with ascending dilutions of calcarea arsenicosum the intestinal catarrh gradually improved, eventually to be completely cured. Appetite returned and the child seemed to have a new lease of life.—*Rivista Omiopatica*, No. 2, 1893.

AN ARSENICUM CASE—Dr. Oskar Hansen, of Copenhagen, was consulted by a shipbuilder of 42 years, who had been sick for fourteen days. (Edema of the face, and slight œdema of the dorsum of the feet. Urine black with a sediment of a blackish-green color. Stool thin and watery of a light color, odorless, no mucus, no blood, but occurring every half hour. At night the evacuations were accompanied by burning pains, exhaustion; slight appetite, thirsty, drinks often but little at a time. His tongue was dry, with a brownish coating. Dyspnoea. Pulse 100. The urine contained biliary coloring matters, otherwise normal. Heart and lungs normal. Epigastric region protuberant. His liver somewhat enlarged and smooth. Slight ascites. Epigastric region dull on percussion. Icterus. Had been in the West Indies and had had a fever of that climate. Arsen. alb. 3x, three drops every two hours. In three days great improvement. The thirst and burning pains in his anus had disappeared. The number of evacuations decreased, his faeces more natural

but mixed with mucous shreds. A feeling of emptiness in the abdomen. Cough with irritation of the larynx, yellow sputa and worse by lying on the left side. No appetite. Phos. 5x, three drops in alternation with china, M. T., three drops every four hours. Rapid improvement followed. He used these remedies for three weeks and then only complained of great weakness in his legs, for which he received chinin. arsenicos. 1x, a grain once a day. A month after he was completely cured.—*Archiv. fuer Homœopathie*, No. 7, 1893.

WHOOPING COUGH.—Dr. Lorbacher, of Leipsic, has observed several epidemics of this disease. He states that it occurring as an epidemic disease there are, besides the usual symptoms, the unusual symptoms, which should be sought out and studied; these will give the key to the epidemic remedy suitable in the majority of cases. A frequent mistake in homœopathic practice is that a result is expected in a few days. He has had only one case where he cured the case in four days. He claims that from eight to fourteen days are requisite to cause the symptoms to lose their spasmodic character, with eventual recovery in four weeks. In fresh cases, with no characteristic symptom he succeeded with bell., ipecac. drosera, and cuprum. Long lasting sneezing, alternating with cough is characteristic of belladonna. In the second stage sepia is of value as an analogue of pulsatilla, in the coughs and respiratory symptoms. The passive stasis is characteristic of this drug and it is indicated in old and neglected cases where the children cough from eight to ten weeks, the night attacks do not cease and the patients do not recover their health. Here sepia is of service. Hansen, of Copenhagen, has called attention to the value of sepia in its relations to the thoracic organs, bronchi, lungs and pleura. In pleuritis he has demonstrated its value in a most striking manner.

Carbo vegetabilis has also symptoms of stasis but with exhaustion, weakness, and paralysis and lack of reaction or no reaction. These are cases of long lasting whooping cough with threatening paralysis of the lungs. In such cases he has had some striking success with carbo vegetabilis, never under the twelfth attenuation — *Allgemeine Homœopathische Zeitung*, Nos. 23 and 24, 1893.

THE SALTS OF POTASH.—The French Homœopathic Society recently had a discussion on the salts of potash. Dr. Cartier finds kali carbon. of value in erratic neuralgias of the thorax. It resembles pulsatilla, and is indicated in lumbago and certain cases of sciatica. Kali sulphur., 3x-6x, had been very efficacious, in his hands, in certain cases of subacute rheumatism, which had been improved but not cured by the usual remedies. It is not indicated in the acute form. Dr. Léon Simon claims kali carb. to be rarely of use in acute affections of the respiratory tract, yet he has seen it succeed in cases of influenza, where there was fever with weakness, sweats, and muco-purulent expectoration. It calmed the cough and caused the fever to fall. Kali bichromicum he has employed with success in case of lupus non exedens of the forearm of long duration. At the time when the lupus was nearly cured the patient commenced to cough and phthisical symptoms were feared (metastasis?). Dr. Parenteau has obtained good results with kali bichromicum in lupus of the face involving the eyes. He also uses kali chloricum in this disease, externally and internally. Conjunctivitis with discharge from the nose and eyes rapidly yields to small doses of the iodide of potash; given in moderately massive doses, it cures scrofulous keratitis. Dr. Boyer treated a consumptive in the second stage, with a continual tickling cough, accompanied by vomiting. Kali bich. in eight days produced an extraordinary improvement. It was continued for two months, when a grave bronchitis came on that yielded to this same remedy. He also recalled the case of a laundress who, although she had cavities in her lungs, was able to continue her work under kali bich. and kali carb. Dr. M. Jousset had a patient with a very fatiguing nocturnal cough which was quickly relieved by kali carb. Dr. Léon Simon states that a case of aneurysm of the arch of the aorta had been reported cured by the iodide of potash.—*Revue Homœopathique Française*, No. 5, 1893.

TREATMENT OF MOVABLE KIDNEY.—Dr. P. Jousset advises removal of the organ in case that the crises render life insupportable. Generally an abdominal bandage will help remedy the symptoms greatly. Applied on a level with the kidney, this bandage should have a concave pad to press upon it and maintain it in position. The medical treatment of the vomiting and pains demands the alternation of belladonna and chamomilla, from the tincture to the third

dilution. These may be alternated from every fifteen minutes to an hour, according to the violence of the symptoms. If the patient suffer from a more or less continuous pain, which is aggravated by the least touch and the jar of walking or riding, with or without vomiting, colocynthis in the mother tincture, 3 drops in twelve spoonfuls of water, and of this a spoonful every two to four hours, generally suffices to relieve these symptoms.—*L'Art Medical*, No. 6, 1893.

MERCURIUS SOL. IN PURULENT CYSTITIS.—Dr. O. Hansen, of Copenhagen, reports the case of N., a farmer, 62 years old, who for five and a half years had suffered from purulent cystitis: darting pains on urination, tenesmus, depression, no appetite, and slept badly; only toward morning did he fall to sleep; stool normal. In two years he has lost thirty-six pounds. Urine contained coagulated blood and tough, slimy shreds. Several remedies were used in vain; the pains increased, vesical hæmorrhage set in, and his general condition became bad. Boric acid irrigations, with one of argentic nitrate, once a week, were tried without result. Frequent urination of small quantities at a time; urine dark brown, often mixed with many whitish-yellow, thick, tough, and fibrous mucous shreds. Much blood mixed with the mucus, and the urine frequently contained dark blood. Burning pain on urination. Great sweating at night, which did not relieve the pain. Merc sol., 3x, 2 grains in water three times a day. Improvement set in at once; his weight increased, the pains were soon gone, and the mucous sediment greatly disappeared. His general condition was good, and the mucus disappeared little by little. He was ordered to take the medicine for eight days and then interrupt it for eight days. The hæmaturia also decreased little by little, and in five months he was completely cured. After recovery a dry, papulo-squamous eruption appeared on his face, which yielded to ars. 2c.—*Archiv fuer Homœopathie*, No. 7, 1893.

ATROPINE IN GASTRALGIA.—Dr. O. Hansen, of Copenhagen, Denmark, was consulted by a girl of twenty-six years, who had been for three years under allopathic treatment without result. Pressive, burning pains in the præcordium, extending into the hypochondrium and back. The pains appeared spasmodically during the day as well as the night. They were worst after eating and, as a rule, accompanied by vomiting of water, mucus, food, and dark coagulated blood, and then frequently extended in a radiating manner over the abdomen. Appetite poor; all kinds of food cause pain, great weakness, and depression. Her præcordium painful to pressure and the pain might be brought on by pressure. Atropine sulph. 2c., 3 drops, three times a day. In a month she wrote him that the pains had greatly diminished, the vomiting had ceased, and there was less depression; the remedy was continued. A month later she reported herself cured.—*Archiv fuer Homœopathie*, No. 7, 1893.

CAUSTICUM.—The French Homœopathic Society recently, in a discussion, presented their individual experiences with causticum. Dr. Léon Simon has always prescribed it after the indications in the classic works, and he has obtained good results with it in cerebral hæmorrhages accompanied by aphasia, from which he concludes that it has an elective affinity for the left cerebral lobe and Broca's convolution. It calms rebellious cough accompanied by involuntary emission of urine. Finally, it is indicated in chronic arthritis with cracking and curvatures of the bones. Dr. Parenteau confirms the statement with regard to cerebral hæmorrhages, but in paralysis from cold he has gotten no good from it. It is of value in hæmorrhages involving the ocular nerves, especially when alternated with gelsemium.

Dr. Boyer finds it very efficacious in hygromas and cysts. He recalls a lady with a cyst at the posterior portion of the neck, who received hepar, 30x, and then causticum, when it disappeared completely. He cured a hygroma of the toe, in a man, with causticum, but a violent attack of gout immediately set in. He recommends it in lachrymal fistulæ of scrofulous and syphilitic subjects. Dr. Cartier has seen facial paralysis cured by causticum, but he cannot say that it has given him favorable results in cerebral hæmorrhage. He has seen cases of Menière's disease cured by it. One of its chief indications is paralysis. He has cured cases of laryngitis where, with the laryngoscope, paresis of the vocal cords was to be observed; it was only active where this did exist. It is also of service where there is cough with difficult expectoration, from paresis of the bronchi. Dr. M. Jousset advises causticum in azoturia, and cited the case of a physician cured of that affection by this remedy. Causticum increases the amount of urea. Dr. Jousset regards pulsatilla as its analogue.—*Revue Homœopathique Française*, No. 6, 1893.

DERMATITIS FROM POISONING BY OPIUM.—Dr. A. Lanz, of Moscow, relates the case of a peasant woman of 39 years, who twice after taking Dover's powders and once after tincture of opium, in seven to eight hours, developed the following symptoms: fever and chills, burning and tense feeling in the skin, loss of appetite, great thirst, coated tongue, and dryness of the mouth. The swelling of the skin began in the face, and the redness—drug erysipelas—extended over the entire body, it being especially pronounced in the face. This was followed by total desquamation; the skin in many places, as the hands and feet, separated in large pieces.—*Allgemeine Homœopathische Zeitung*, Nos. 25 and 26, 1893.

ARSENIC IN ASTHMA.—Dr. Murray has obtained excellent results from a long course of arsenic in asthma, in essential asthma as well as in the form with emphysema. The results are good, but the remedy must be given for a long time before the influence is manifest. In the beginning, in order to alleviate the respiratory symptoms, he prescribes: tinct. stramonium, 8 gms. (3ij); ammon. carb., 4 gms. (3j); sodium carb., 12 gms. (3iij); magnesia carb., 4 gms. (3j); powdered rhubarb, 1.25 gms., (grs. xx); chloroform, gtts. 20; aq. menthæ pip., 200 gms. (3vjss), three spoonfuls per diem. When, under the influence of this palliative, the symptoms have retroceded enough, he begins with the use of arsenic, giving 5 drops, twice daily, during the course of the meal, and a spoonful of the mixture before going to bed. Usually, after three months of treatment, not only will an improvement be manifest, but even a complete cure. It was especially efficacious in asthma of children and emphysema not complicated by bronchitis. Bronchitis with emphysema seems to be a contra-indication.—*Allgemeine Homœopathische Zeitung*, Nos. 25 and 26, 1893.

NUX VOMICA IN CONGESTIVE HEADACHE WITH NERVOUS SYMPTOMS.—Dr. Stiff, of Leipsic, was consulted by a man of 40 years who had suffered for two years from a peculiar headache. It would begin in the evening and last the entire night. For a half year he had grown worse. His headache then began mornings, reached toward evening its maximum, and wrought him into such a state of excitement that he could not bear to be in the room. He spoke and acted wildly, wanted to jump out of the window, and only became quieter when he got into the open air. Gradually other symptoms added themselves to the increasing headaches: roaring in the ears, supraorbital neuralgia, vomiting, pains in the joints, transitory redness of the skin, and a depressed and discouraged condition of mind that nearly drove the patient to suicide. He had attempted it once, but had been rescued. He was a brunette, of moderate size, quite well nourished, with a venously reddened face and strikingly prominent, glistening, and dark eyes. He leaned his head on his hand, complaining of a frontal headache that nearly drove him insane. Vertigo, torturing ideas of suicide, anorexia, and constipation. His liver was found hyperæmic, his heart's action greatly increased, præcordium sensitive to pressure, and great hyperæsthesia of the skin; circulatory disturbances upon a nervous basis. Nux vom., 3x, 3 drops every three hours. In two days he had a critical diarrhœa of a blackish-green color, with rolling and pains in his abdomen, something that he never before had had, and his headache and suicidal ideas disappeared, to give way to a feeling of well-being. His anxious expression, cutaneous hyperæsthesia, and hepatic hyperæmia were gone. Nux was continued in the 6x. A few weeks later he returned, on account of restlessness and insomnia from taking the remedy too long and continuously. These ceased on interrupting the remedy. For two months he was free from his headaches, when he returned for treatment, saying that they had returned with violence, but without the suicidal accompaniment. Nux no longer helped, and he disappeared.—*Allgemeine Homœopathische Zeitung*, Nos. 1 and 2, 1893.

STRAMONIUM IN NYMPHOMANIA.—Stramonium may excite a decided nymphomania, during which the woman, though very chaste when in her normal condition, becomes exceedingly lewd in her songs and speech. She may become very violent in her manner. Often these symptoms occur in women before menstruation, in which case stramonium acts admirably. The menstrual flow is apt to be very profuse, showing that it is the high degree of congestion that produces the nymphomania. There is a strong odor about these women reminding one of the odor of animals in the rutting season.

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SCIENTIFIC PRESCRIBING.

BY EDWARD CRANCH, M.D., OF ERIE, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania,
September 19, 1893.)

1. A SCIENTIFIC prescription is one that is arranged by a rational use of all ascertainable facts, regarding first the patient, next the action of drugs, in such manner as to restore health most permanently to the patient.

2. The condition of the patient is to be studied by every means in our power, by inspection, palpation, auscultation, chemistry, microscopy, and history, as given by the patient and by others, all arranged not so much with a view to naming the case as with a view to selecting the mode of treatment. Names are useful as satisfying the present demands of society or as an index to existing works of reference, but names are of no intrinsic value, for it is better to cure a patient before the name is known than to have to perform a post-mortem to verify a diagnosis.

3. The best knowledge of drugs comes from carefully-studied experiments upon the healthy, either voluntary, as in regular provings, or involuntary and accidental, as in cases of poisoning. Clinical evidences are often fallacious, and should be corrected as far as possible by re-provings.

4. From a study of the best provings we find that drug action, from one or a very few doses, proceeds in alternating series or waves of action and reaction, till the whole force of the drug is exhausted. Thus opium, whose direct action is to cause stupor, is found in its first reaction to cause wakeful restlessness, succeeded, without new administration, by another stage of stupor, less pronounced; another stage of nervousness, and so on, till the whole force of the drug is spent. A little care would and does ascertain the usual length and frequency of such alternating states, which are also manifested in the phenomena of disease when not interfered with.

5. The fuller the proving of a drug, the better can it be used in prescribing and the better will we be able to ascertain whether we are using its direct action or its reaction.

6. The essential of a homœopathic prescription is that it be given to remove by reaction symptoms like those of the direct action of the drug prescribed.

7. As a necessary corollary to this rule, it follows that all violent or prolonged direct action must be avoided by the skillful attenuation of the dose and the prohibition of its too frequent repetition.

8. Under the operation of the law of alternating or wave-like action of all forces, a return of the first symptoms may take place, but if the benevolently-acting first dose be left a little longer unrepeated this apparent relapse is followed by a fresh reaction and the cure goes on more quickly and often without further interruption. If the improvement halt beyond a reasonable time, to be inferred from the known history of the drug, then, if the symptoms are still the same, the dose may be repeated, in the same form or more or less attenuated, and the vital forces will once more be roused to healthy activity. If new symptoms arise, first consider carefully whether they belong to the regular properties of the given drug (and this will be the more likely in proportion to the crudity of the first dose). If the new symptoms belong to the given drug calmly await their subsidence, unless they are so violent as to demand an antidote. Next consider and inquire if the new symptoms had previously existed in the patient but had been absent for some time, being suppressed by later states of the disease or of its treatment; if so, again await, and they will commonly subside, all with the one original, attenuated, potentized dose. If, however, the strange symptoms are wholly new, and evidently or probably due to the disease or to some new disturbing force, then look quickly for a new remedy, not to mix in or alternate, but to give alone and in single dose, until its favorable

action is exhausted or further changes demand new measures of relief.

9. All that part of the drug-action that agrees with the existing disease-state is expended homœopathically in the attenuated, readily-absorbable form of high potencies, in producing the healthy reaction of the suffering patient, who will, if his vitality is not all gone, come at once into the road toward health, needing no repetition or change of dose so long as improvement continues, and improving permanently, because from the now roused forces of nature, and not from the restraining action of crude drugs present in the system, whose subsequent reaction will often be disastrous and whose only hope of real help lies in their second reaction, which may be favorable if the patient endure so long.

10. In the case of the attenuated drug, it is more powerful for good because its known affinities draw its fine particles at once to the very seat of disease, and that seat, responding to the delicate yet powerful stimulus, begins of its own vital power to throw off the diseased state, while, at the same time, the dose is so small that that portion of it that has touched parts of the organism not involved in the disease is at once thrown off by those healthy parts without subsidiary disturbance.

11. Only that employment of drugs which seeks to profit by *reaction* is homœopathic and is permanent. Direct action is temporary and irregular, and its benefits are generally lost in the resulting suppression or injurious reaction. In such cases, the *second* reaction is the only hope of the patient, and this is often nullified by the persistent dosing of the crude drug until, by and by, a state is reached which Hahnemann speaks of in these terms (*Organon*, fifth edition, §§ 75 and 76, translated by the writer): "These maltreatments of the human system, produced through the dangerous skill of the allopathists (in modern times the most injurious), are the most distressing and incurable of chronic maladies, and I regret that for their cure, if they are driven to any height, almost no remedy seems to be found or known to have been invented."

"The all-merciful Helper has, by means of homœopathy, given us aid only against natural diseases; those others by false skill mercilessly forced upon the human organism, internal and external—often by year-long bungling and crippling with pernicious medicines and manual treatment—*must be restored by the vital force itself* (aided by abundant suitable help directed against any chronic miasm still perhaps lurking in the background); that is, if the vital force

be not too much weakened through former misdeeds, and is able to devote years more to the execution of its now enormous task.

“For the normalizing of those countless cases so often made abnormal by the allopathic art of non-healing, no mere human system of cure does or can exist.”

12. The above paragraphs are not in the fourth edition, so they are the expression of Hahnemann's mature observation, and offer a field for inquiry: What are we to do in these countless abnormal cases? Homœopathy will aid the vital forces till they will respond no longer; then we must face the inevitable, and make the patient as comfortable as possible by any means in our power. Experience shows, however, that the reactive power of the true *similimum* is often exerted on the very brink of the grave, and that it will palliate even in incurable cases, so that this seeming loophole for non-homœopathic measures is not so large as it might at first sight appear.

13. Homœopathy is not, as Roberts Bartholow told his classes, an “exclusive dogma;” it is a fixed law of action and reaction, and explains all real cures. Nothing but reaction ever really cured any patient; only, *first* reaction is better and safer than *secondary* reaction, without one of which the patient is doomed to lifelong use of drugs, or else to go without any relief whatever.

14. Study in the properties of drugs should be directed to include the fullest knowledge possible of direct action and reaction of drugs, so that we may know which we are using.

If we are really using true homœopathic reactive forces, we need to be very careful how we repeat too often, or we may only fix the original disease more firmly upon the patient. If the patient improves with the frequent repetition of the dose, we are most likely not giving the exact *similimum*, or we are really prescribing allopathically with attenuated drugs.

Antimony in large dose will remove pulmonary œdema by diverting it to the bowels; the 200th potency repeated will do the same. Is either prescription homœopathic? Are we not merely suppressing a symptom by transferring its field of action? If, however, life is threatened, is it ever excusable to do this, if we cannot find the true *similimum* which would do it in one dose?

A wash of nitrate of silver, or the same remedy given in high potency and repeated doses, will clear away a blennorrhœa of the conjunctiva. If the sight is threatened, is it ever safer to do so than to hunt the *similimum* in the usual manner? When the *materia medica* is perfect, exact homœopathy must reign supreme, but till

then we must often be satisfied to come short of our ideals, especially in cases already made abnormal by unskillful handling.

15. It is not homœopathic nor in any way scientific to give unproven drugs in disease, therefore when we are asked by this or that pharmacist to give a lot of tinctures or, perhaps, mixtures, for their direct action, let us wait and faithfully prove them, and find thus their true fields of permanent usefulness, which will often be directly opposite to the uses for which they are at first empirically recommended.

16. As illustrations of drugs already known to have a double action, accordingly as given for direct action or for reaction, let me instance nitro-glycerine, also called glonoin or tri-nitrin, belladonna, aloes, podophyllum, rumex, rhubarb, and dozens more. Is it not likely that sabal serrulata, salix nigra, passiflora, and scores more will be added to the double list as soon as they are thoroughly proven?

Every pharmacy should maintain at its own expense a bureau of provers, whose report should be published with each new drug put upon the market. In the case of drugs like heloderma, whose direct action is obviously inadmissible, physicians have been requested to furnish provings. Such work should be done by a paid staff, as well rewarded as the staff of contributors of any prosperous journal. Then, perhaps, our art will take a new development, and our use of new drugs will cease to be a reproach to our avowed method of prescribing.

17. Our present methods are, many of them, as crude as the crude homœopathy of the old school, when they seek to rouse reaction by washes, gargles, cauteries, castor oil in diarrhœa, corrosive sublimate as an antiseptic in dysentery, Koch's lymph for phthisis, erysipelas for cancer, cerebrine for lunacy, vaccination for smallpox, quinine in malaria, ipecac powder in vomiting—all which sort of measures Trousseau calls "substitutive treatment."

Let us be true to homœopathy, and she will never fail us in the hour of need!

ANTIPYRIN IN EPISTAXIS.—In idiopathic epistaxis Dr. Guénot has frequently found a local application of antipyrin to be of great service. As a rule he employs a solution of the strength of 1 in 5, but in mild cases a 1 in 10 solution is strong enough. He directs the patient to pour a little into the hollow of the hand and to inhale it vigorously. In the case of young or intractable children this method is of course not applicable. Here a syringe must be used, and after the nostrils are filled they should be compressed for a moment so as to allow the antipyrin time to act.—*The Lancet*, Aug. 19, 1893.

A CEANOTHUS CASE.

BY JOHN L. FERSON, M.D., PITTSBURGH, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania,
September 19, 1893.)

ON July 19, 1892, Mrs. C., a short, stout woman, of florid complexion and even temperament, called and made complaint as follows: Constant dull ache in the occiput and forehead; if it does stop for a time, which happens occasionally, it begins in the occiput and then appears in the forehead; always worse in the occiput, sometimes becoming very severe; it feels heavy, as if the head must fall back; too heavy to hold up; ameliorated in cool, open air, when lying down, and by pressing firmly front and back, or tying tightly; she can go to sleep easily in spite of headache and sleeps well, but finds the head aching just the same on awaking; face and head burn at odd times an hour or so at a time, but the face does not flush; relieved in cool air; from 9 A.M. till after dinner each day hands tremble continuously, and if she walks the knees feel weak, as if they would give way. Shortly after dinner these symptoms pass off, to reappear next morning. I found the spleen enlarged and tender, with dull, aching, smarting, burning pain. This lady is the mother of three healthy children, and has always herself enjoyed perfect health. The above symptoms had been present for several weeks, gradually increasing in severity, and constituted the sum total of her complaint.

After taking her history, I found I had no time then to make a careful prescription, and the symptoms picture presented was one which I was not familiar with, and was therefore unable to prescribe for without study, so I did what I presume many of us do at times: I did a slovenly piece of work and gave ceanothus, five drops every four hours. The reputed value of this drug in the cure of diseased conditions of the spleen was the sole basis upon which it was given, and, contrary to one's usual experience in such slipshod work, the result was gratifying. At leisure, afterwards, I looked up the literature of the drug, and found my *Medical Index* referred to an article in vol. xv., page 67, of the *HAHNEMANNIAN MONTHLY*, entitled "Notes on Materia Medica," by Dr. Clarence Bartlett, in which I found quoted Dr. Burnett's experience with ceanothus as follows: "In one patient to whom I gave ceanothus it produced great nervous

excitement, with chilliness and loss of appetite. The patient (a young lady) felt as if her nerves were shaken, so that one day at dinner she could scarcely hold her knife and fork. The chilliness was confined chiefly to the back. The medicine was discontinued, when all the symptoms disappeared, only to reappear on resuming the drug." The feeling as if the nerves were shaken so that she could scarcely hold her knife and fork at dinner corresponded so nicely to Mrs. C.'s continuous trembling from 9 A.M. till after dinner, that I was glad I had *happened* to give it, and awaited a report with interest. I did not see the patient again till October 10th, when she reported that the medicine had promptly and entirely removed all symptoms, those of the head being relieved first. However, for a couple of weeks past the symptoms had been returning gradually, hence her visit. Having failed in the meantime to provide myself with a potency, I had to give the tincture in drop doses. On October 22d she called for medicine for one of her children, and reported the same prompt and efficient action as previously, and since that time there has been no return in any measure of any of the symptoms. The action of *ceanothus americanus* in this case was so prompt, so thorough, and so lasting as to justify us in placing the symptoms of the case presented among those belonging to it, especially when it in part conforms to the proving recorded by Dr. Burnett.

WHAT IS A LEGITIMATE DRUG-PICTURE?

BY M. W. VAN DENBURG, A.M., M.D., FORT EDWARD, N. Y.

(Read before the Homœopathic Medical Society of the State of New York.)

DRUG-PICTURE is a term so often used by Hahnemann and his followers that it has become a legitimate expression in the application of the law of similars. Presumably a certain unity of symptoms, such as was presented in some one case of proving or poisoning, is what is meant by the term. But in the practical application of the law, little regard is had to the unities presented in the provings.

A composite picture is made up from all or any number of provings, and combines toxic and provers' symptoms without regard to source or manifestation. Is such a picture legitimate?

Here is a drug-picture from an actual proving: "Chill at 3 P.M., lasting for two hours; at the beginning, frontal headache, yawning, general malaise, great weariness and weakness, chilliness, and anxiety; sallow, yellowish face; sunken, listless eyes; the conjunctivæ reddened; tongue furred, yellow; nose and upper lip excoriated; gradually the chilliness becomes a strong chill, with increased headache, small, frequent pulse, oppression and constriction of the chest; tearing pains in the nape and upper limbs; pressure in the tonsils; pressure in the epigastric region; distension in the abdomen; after two hours' chill, moderate heat, lasting until 8 P.M., with hot, dry mouth and little thirst; after the heat, very slight sweat, during which he fell asleep; at first the sleep was with frequent startings, but after midnight he slept quiet; on waking in the morning, weary, and a feeling as if beaten."

Here we have a drug-picture made up of a large number of symptoms, but it is an unmistakable unity. Suppose we look for a moment to see how this unity has been broken up and distributed. Take the "tearing pain in the nape and upper limbs;" in one place we find "tearing pain in the neck during the chill." Fully a page from this we read, "tearing pain and stitches in the upper limbs during the chill." How are we to know that they were so closely associated as to practically be one and the same symptom?

"Tongue furred, yellow," says the picture.

"Tongue yellow."

"Yellowish, furred tongue with the chill." Two have been made out of this. One more example, and enough.

"On waking, weary, and a feeling as if beaten."

No less than four symptoms have been made out of this. Here they are:

"Getting awake in the morning weak and depressed."

"On waking, weak, etc."

"Weak and prostrated on waking."

"Tired and depressed on waking in the morning."

These are printed together in the order given, and there is no doubt as to their origin.

It is easy to imagine what must be the prolixity of the distribution of the remainder. The example is scattered up and down several pages, commingled with the symptoms of at least half-a-dozen or more provers. Would a drug-picture, constructed haphazard from this motley combination, be a legitimate drug-picture?

The law of similars is not a law of theories; it is a law of nature.

It is an "order of manifestation of natural phenomena," as Spencer terms natural law. Now, is this a full compliance with the law, or is it a bungling, half-way makeshift that constructs a composite drug-picture in the place of a natural unity exhibited by some prover or toxic case?

THE SPHERE OF USEFULNESS OF ELECTRICITY IN NERVOUS DISEASES.

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(Read before the National Society of Electro-Therapeutists, September 28, 1893.)

THE subject of my paper is one bristling with so many difficulties that in the short time allotted to me for its consideration I can treat it only in the most general manner.

Among the nervous diseases there are not a few to be considered as purely psychical; there are others which, without being simply psychical, are yet not due to permanent organic change that we can at present identify pathologically; and there are still others dependent upon conditions of irritability set up in certain areas or aggregations of cells in the nervous system by some morbid state in some peripheral non-nervous part. These, taken together, can be put into one class.

On the other hand, it is now an axiom in neurology that when a nerve-fibre, excluding such in the peripheral nerves, is subjected to a solution of continuity, the segment distal from the originating cell undergoes degeneration and can never be restored. Diseases with such conditions will make a second class.

Here then are two great classes of nervous disease, in one of which, theoretically, at least, there is no possibility of cure; in the other, cure may be effected, and has often been effected by the most diverse therapeutic measures, embracing all between pure mental shock, such as fright, through hypnotism or suggestion, mind cure, etc., up to and including, at the other extreme, the actual cautery.

Now there exist to-day in the medical profession two sections, one holding that there is absolutely no therapeutic effect to be obtained from the application of electricity in disease, apart from the influence of suggestion; the other, made up of those who admit a varia-

ble degree of influence from electricity in disease, from a minimal amount of curative effect to that of a wonder-working panacea.

Who is to decide between the two claims? Or, if we all here admit that some amount of therapeutic effect by electricity does exist, which one among us can lay down authoritatively the limitations of such effect?

Perhaps it will be said that each physician must be guided by his own experience in the matter, and that then a Congress of Physicians could settle the matter by vote. But this will hardly meet the difficulty, for objectors will demand that all the physicians so voting shall be equally good diagnosticians.

Some, too, are held back by considerations based on physics from applying electricity in certain forms of nervous disease. Personally, from such *a priori* reasons, I have never used electricity in epilepsy or in the treatment of brain tumor.

Will the results obtained in large hospitals from the use of electricity be accepted? If the hospital be a public one and the application be entrusted to the average nurse found in such hospitals, I should unhesitatingly say no. It has been so often a matter of pain and disappointment to me to find that in such cases the applications were made improperly, with a wrong form of current, or in strength not ordered, or in some other way exactly opposite to my directions, that I do not now prescribe electricity in my hospital practice except under specially favorable conditions.

While it may be said, and with truth, that the influence of suggestion enters largely into every therapeutic measure, and while it also may be said that, as our mission is to heal the sick, it makes but little difference whether or not suggestion is a factor in the cure, yet we are here to consider the more scientific aspect of the question: Does electricity *per se* cure in nervous diseases; and, if so, which of such diseases, and to what extent?

My own position on this question is a rather conservative one. I know that under the use of electricity I have in many instances seen great improvement. I do not know that these actual cases would not have done as well without electricity as with it, but I do know from my experience and study that similar cases in general do not do so well without it.

It will be observed that in the foregoing remarks I have used the word "electricity," for it is not my purpose to enter into any discussion of the limitations to or the indications for the use of Faradism, of Galvanism, or of static electricity. I have used all of them, but

have been disappointed in the results obtained from the latter. In this I know that I shall not be supported by many who are present. But here again *a priori* considerations may have swayed me into not using it often, and also the fact that the test-cases in which I applied it were the secondary contractures in hemiplegia, where faithful applications during several weeks made no change whatever.

On the other hand in peripheral multiple neuritis I would feel myself guilty of neglect did I not give galvanism as the main part of my treatment. In traumatic neuritis of the brachial plexus I have seen what I consider to be good although not brilliant, results from the use of galvanism. In facial paralysis of rheumatic origin my results have varied, with the balance not in favor of electricity.

In degenerative diseases of the spinal cord I have achieved nothing by the use of electricity. I have applied galvanism repeatedly in locomotor ataxia without any beneficial influence upon the disease itself. And so likewise in primary lateral sclerosis. In disease affecting the blood-supply within the spinal canal I have seen some remarkably good results. In poliomyelitis anterior my results have varied; in some cases they were admirable, in others the reverse; and the explanation that I would give is that in the cases wherein improvement followed there could not have been very great destructive change in the motor cells related to the affected muscles. While I must again insist on the hopelessness of trying to restore a destroyed cell or nerve fibre within the central nervous system, I also insist that our only way of determining whether complete destruction or a reparable injury only, has been left after an attack of poliomyelitis, is in the systematic and patient use of electrical treatment. Where cells retain some considerable amount of structure and a latent activity, so to speak, the influence of the galvanic current is in my opinion of high value.

In progressive muscular atrophy of the type of Aran-Duchenne I have had two cases with great improvement. In one of the cases sent to my clinic I advised the use of galvanism and gave this advice to the attending physician. I learned some months later that the patient had improved so much that she was able to attend to her house work, and could even carry a bucket of water with the atrophied hand and arm. The remarkable feature of this case (of whose further history I know nothing) is that faradism was administered instead of galvanism which had been ordered. Phosphorus had also been prescribed and administered as an internal remedy. In view of the later conclusions by investigators that the progressive

muscular atrophies are not spinal diseases at all, with one exception, but are so-called muscular diseases or are neuritic (but I am inclined to the view that still later investigation will show that those now classed as muscular will be found to originate in the nervous end-organs in the muscle-fibre), it would be better practice to give electrical treatment to the muscles and peripheral nerves more than to the spinal cord. At the same time it may be proper to state that so able an investigator as Erb considers that although the first onset of such muscular disease may be apparent in the muscles, the real *fons et origo* is still in the cord as some nutritional change in its trophic cells.

In the paralyzes of children of cerebral origin I have seen some remarkable results. And I am of the opinion that the activity of the muscles brought about in the paralyzed limbs by the use of the faradic current has an educational and reflexly developing influence upon the related cortical areas. In one case especially, the activity of the muscles caused in the way indicated soon attracted the child's attention and, as it were, taught him to move the muscles and thus the limbs. The damage to the brain cortex in this case must have been slight, but it is only fair to give credit to electricity for a result that possibly would never have been attained otherwise.

Erb's paralysis is one form of traumatic paralysis that in my opinion is admirably suited to prove the beneficial effects, and often with remarkable rapidity, of the application of galvanism provided the condition has not lasted more than a year or so. All my cases of this trouble, with one exception, have lasted less than six or eight months. The excepted case was two years old when brought to me, but after some weeks' use of galvanism showed no improvement, and the case was withdrawn from further treatment. The other cases showed improvement after a few applications of the current, and continued to improve, but I was unable to keep them under observation until complete recovery occurred, as the parents were satisfied to cease coming as soon as the little patient had obtained a fair amount of movement of the upper arm.

In traumatic paralysis due to pressure at a later period of life, I always use, or in consultation cases advise, the systematic employment of galvanism. Yet, in one case of crutch paralysis I saw immediate improvement follow the application of the faradic current in testing the muscles. Acting upon this hint I used faradism alone, and although partial reaction of degeneration was present, two further applications completely restored the affected muscles.

In exophthalmic goitre I consider the use of galvanism to be a necessity, no matter what other treatment be employed. The rapid and sometimes great fall in the pulse-rate while the current is passing, as I have demonstrated it more than once to my classes, teaches me that whatever be the part of the nervous system essentially involved in the causation of the symptoms of this disease, it is affected in a marked manner by this method of treatment, and, further, the relief to some of the other symptoms (especially the dyspnoea) that follows the application makes me almost willing now to treat such cases solely by galvanism.

In facial spasm I have not seen any result from the employment of electricity. This trouble so notoriously defies all forms of treatment, and its cause being in most instances not in the nerve itself, the adherents of electro-therapy need not consider failures in this trouble to be valid arguments against it.

In spasmodic affections, such as epilepsy, chorea, etc., I have not ventured to use electricity, chiefly from *a priori* considerations of one kind or another. And so with the insanities and their relatives, the morbid fears.

In this incomplete, yet perhaps too long, statement of personal experience, I do but carry out the intention of offering subjects for discussion by those here assembled, and I am quite sure that on many of the points presented I shall find opponents. It must not be forgotten that throughout the whole matter the personal equation comes in in almost every instance, and that in the diversity of apparatus, in the strength of applications used, in the very size of the electrodes employed, we may find the key to the differences in effects obtained.

It seems to me that the greatest result possible from a congress of electro-therapeutists at this time would be the establishing of a practical standard method of expressing the current strength affecting the patient, perhaps after the method proposed and used by C. W. Müller, of Wiesbaden. Müller had recognized that the milliamperemeter does not tell us all that we ought to know of the current as it enters the patient; and his well-known fraction, whose numerator is the number of milliamperes and whose denominator is the surface area of the electrode expressed in square centimeters, may serve as the numerical expression, as he maintains it does, of the current-concentration at the points of application. His method has not yet found acceptance.

The solution of the problem is a pre-requisite to the foundation of

any scientific galvano-therapy. Similar problems exist in the use of faradism and of static electricity in its different modes of employment.

May we not hope that it is reserved for the National Society of Electro-Therapeutists to remove some of the obstacles to the settling of these questions, and thus to advance the usefulness of electricity in diseases of the nervous system to something like scientific certainty?

APPENDICITIS.*

BY WILLIAM B. VAN LENNEP, A.M., M.D., PHILADELPHIA, PA.

I HAD the pleasure, some two years ago, of reading a paper on this subject before the Congress in Atlantic City. At that time the importance of the disease was not generally recognized, and the views I expressed caused considerable criticism. It has been, therefore, a source of satisfaction to note since then the change in medical opinion and that of the public generally. In fact, to-day, in enlightened circles, when the diagnosis of appendicitis is pronounced, the family want to know when an operation will be undertaken, just as the first question asked by the Yorkshire miner, when a man's head has been injured, is "when will the bore un?"

With this train of thought in my mind, after reading the request from your secretary that I prepare a paper on appendicitis, I turned to my table of operations and records, and found, to my surprise, that figures showed that the disease is not recognized in time and not operated early enough. I find that I have been called in to but few cases where I did not find it high time to operate; that I have seen but few cases in which nature did not come to the rescue, and without her the patient would have died before surgical assistance was at hand. What is still worse, I find several cases in which the operation was done too late, and a few in which a post-mortem examination or a narration of the symptoms showed that the danger was not recognized at all.

On this account I may be pardoned for taking a subject which to the majority of journal readers is somewhat trite. I have selected

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the following cases from a number I have met with since my last paper, as illustrating the different phases of the disease that have come under my observation.

Surgeons are accused, and in some instances no doubt justly, of being too prone to recommend operation. This is particularly so in appendicitis, some men going so far as to say that every case should be operated as soon as the diagnosis is made. I have therefore reported several instances in which operative interference was not deemed necessary, and desire especially to emphasize the careful and anxious observation to which they should be subjected. It would be far safer, however, to operate every case in which appendicitis is *suspected*, provided such an operation were done by an experienced laparotomist, than to keep on with the at present too frequent conservative, or, more correctly, dilatory plan of when all others fail call in the surgeon or the undertaker !

CASE I.—A young lad, patient of Dr. Edwin H. Van Deusen, was taken with vomiting, cramps in the epigastric region, constipation, slight tympanitis, tenderness to point pressure over the appendix, this region being somewhat tumefied, and the abdominal wall fixed ; heavily-coated tongue, showing the marks of the teeth ; temperature rise of but a little over a degree and a moderate pulse acceleration. I saw him within twenty-four hours, when the attack was practically over. The bowels were then unloaded by an enema, followed by a mild laxative, and the appendical tenderness disappeared *entirely* and promptly. This was his second attack, and, so far as I know, he has had no other in the year or more that has elapsed.

This is a common picture, and would be diagnosed as an ordinary bilious attack or indigestion, were not localized tenderness looked for. It is then of the utmost importance that every case of abdominal "pain" be subjected to a *physical examination* for points of tenderness ; a persistence of this symptom alone, especially without marked general amelioration, demands the closest and most anxious attention. Such an examination is far more important and life-saving than an early one of the chest for pneumonia, pleurisy, endocarditis, etc. Just such an attack may seal the patient's fate in thirty-six hours or less. That I am not an alarmist the following case will show :

A lady was taken with cramps when beginning to menstruate, and was prescribed for as an office patient by her physician. A tender tumefaction was found later on, but considered too near the middle line. Her general condition became more serious, and she

was doomed in forty-eight hours. The appendix was long and attached close to the brim of the pelvis; had become gangrenous and perforated; protective adhesions were imperfect, allowing leakage and general peritoneal infection.

Again, what did this lad die of? He was taken with cramps after going in bathing, vomited, was constipated, the belly swelled, and he was dead on the third day.

In Case I. the probable condition was a twist or kink of the little organ, an attempt to rid itself of some fæcal matter, or possibly a foreign body. The absolute freedom from tenderness afterward would lead us to infer that pathological changes in the appendix were slight, if present at all.

The question naturally arises in this connection, is such a patient doomed, sooner or later, to operation or death from this cause? If distinct pathological changes have occurred in the organ, unless perhaps it becomes completely occluded by inflammation on the inside or adhesions outside, such a termination seems probable, although death from other causes may win the race.

CASE II.—A former student of mine seems to have gone through an experience of this kind. He was subject to "bilious attacks" which doubled him up with pain, and lasted about twenty-four hours. I finally saw him in one of these and diagnosed appendicitis. The picture was that of Case I., plus dysurea and retention of urine. There was no tenderness of the appendix nor tumefaction between attacks, although the former persisted for several days, and, after going through with some fifteen or twenty, he has now been free from them for over three years. Whether this was an instance of appendicular colic from malposition or twists, or whether the "catarrh" finally resulted in complete occlusion we cannot say. Such occlusion has not been produced by involvement of the peritonæum and adhesions, for no tumefaction is present. If the lumen is closed by stricture, some tenderness should be present, and, sooner or later, the resulting cyst or concretion will be heard from.

CASE III. belongs to the same class, but shows the protection afforded by nature, without which the recurring attacks must have proven fatal.

A young Englishman, patient of Dr. W. W. Van Baun, had gone through with a number of attacks, in the last one of which the doctor saw him and made the diagnosis of appendicitis. The tenderness, however, persisted, and a distinct tumor could be felt. His general health was broken down, and he was incapacitated for work;

the tongue was heavily coated; the bowels constipated, with occasional diarrhoea; the skin sallow. Section showed a mass of very firm adhesions about the caput coli, between intestinal loops and omentum. By carefully separating these, and following the anterior muscular band of the cæcum, the appendix was found, teased out, and excised. It was strictured, cystic, ulcerated, and contained a concretion. The abdomen was closed, layer by layer, and healed without reaction. The effect upon his health and local symptoms was striking.

CASE IV.—S. P., æt. 50 years, had been the rounds for a persistent abdominal pain, which disabled him from work, and which was aggravated by attacks of "indigestion." The symptoms led me to hesitate between catarrhal appendicitis and stone in the right kidney. Guided by repeated examinations of the urine, and the ever present tenderness to pressure over the McBurney point and nowhere else, I suggested excision of the appendix after an exploratory section. This was readily agreed to. The appendix was perfectly free, stiff, curved forward and outward, and, in contrast with the surrounding intestinal loops, showed that it was cicatricial, *i.e.*, had been subject to a long continued inflammatory process, presumably of a low grade. Its walls were much thickened, its lumen encroached upon, particularly about one-third of the way from its base, where there was a distinct stricture. The operation was followed by relief of the pain. Nothing else abnormal was found in the abdomen.

This form is probably the most dangerous, because, when perforation takes place, it is apt to do so from gangrene or sneaking ulceration, and the abdominal cavity is not protected by adhesions. Every case of unprotected perforation I have seen has originated in such a process. The indications for operation were the persistent pain, localized tenderness, and the resulting invalidism.

CASE V.—Was under my care for two and a half years while a student at the Hahnemann Medical College. He has not had an attack, but was never completely free from pain and tenderness of the appendix to pressure. The organ could be made out, the patient being quite thin, and therefore must be thickened. Whenever he gets run down, or relaxes in his attention to diet and the regularity of the bowels, there is increased pain and aching. Such an aggravation is apt to terminate with a diarrhoea. Under careful dietetic and medicinal treatment, according to indications, this condition has improved, instead of growing worse, and I have so far refused his request for operation. My reasons for this are that he has not had

a distinct attack, the condition is improving, his general health is not affected, and he is not invalided; he is thoroughly acquainted with the threatened dangers, and has been within easy reach of surgical assistance. He will never have a second attack.

Such cases are quite common, and the question of operation has caused me a great deal of thought and anxiety. Progressive character of the disease, increasing frequency of the attacks, symptoms between attacks, particularly when the appendix is not protected by adhesions as shown by tumefaction, impairment of the general health and nearness of the patient to surgical aid, are the principal deciding points.

CASE VI.—Mr. W. G. W., patient of Dr. Josephine Van Deusen, was referred to me at the close of his third and severest attack in five months. The remaining symptoms were the cachectic appearance, the heavily coated, indented tongue, the constipation, slight intestinal paresis, and distinct but fading tenderness of the appendix which could be made out. Under medicinal treatment according to clear indications, attention to diet and the bowels, the tenderness is practically gone, while all the other symptoms have disappeared, and his general health has improved to a marked degree. He states that he does not know any longer that he has an appendix. Four months have elapsed without an attack, and, while this is no guarantee against future danger, it shows the value of dietetic, hygienic, and medicinal treatment, when applied with an intelligent appreciation of the impending danger. Although strongly opposed to an operation, he is willing to yield to my judgment in the matter, and I have decided to await further developments, (1) because of his hearty and conscientious co-operation in preventive treatment; (2) because both his physician and he are so thoroughly aware of the character and dangers of the affection, that a surgeon will be on hand at the very beginning of his next attack; (3) because the general tendency is toward a cure, or rather, toward postponement of attacks, disappearance of symptoms and improved health. Such cases are by no means uncommon.

CASE VII.—Mrs. H. D., æt. 46, patient of Dr. A. M. Barnes, had gone through with six attacks, in the last two of which I saw her. The picture was a typical one, the tumefaction and, particularly, the pain, being the characteristic symptoms. The tumefaction persisted for a long time, while the tenderness never entirely disappeared between the attacks, the interval between the last two being the longest (two years).

Operation was undertaken principally for the persistent symptom, agonizing pain, which caused her to beg for relief at any cost, and which had kept up for over five days. Every previous attack had subsided completely in less than three days. The ordinary treatment had been carried out as before, but without relief. Palpation showed the point of most exquisite tenderness over the appendix, but the region of the gall bladder was also sensitive. Section revealed a free, erect, thickened, congested appendix, which was strictured internally. It was excised.

Remembering the gall bladder, the incision was enlarged upward, and this organ found imbedded in a mass of rather recent adhesions. Fearing a possible mistake in diagnosis, I closed the lower portion of the wound, passed a suture through the wall of the gall bladder "for future reference," packed gauze around it and awaited developments. All the symptoms disappeared, and therefore nothing further was done, the upper, open portion of the wound healing by granulation.

The question of mistakes in diagnosis in appendicitis has been elaborately emphasized (Dennis), and it behooves all of us to be on the lookout for possible errors.

In talking with a surgeon in New York the other day, he told me of a case in which he had removed a diseased appendix during what seemed to be an attack, and the patient passed a renal calculus the next day!

Another interesting case was one I operated with your secretary, Dr. F. P. McKinstry, of Washington, N. J., last winter.

CASE VIII.—Miss M. J., æt. 18, was suddenly taken with pain in the right iliac fossa without apparent cause. The tumor was quite near the middle line, dull on percussion, and attached to but distinct from the uterus. The picture, however, was that of progressive peritonitis, and when I saw her, forty-eight hours after the onset, the indications were unmistakable for operation. The diagnosis made was septic peritonitis from a tumor, probably ovarian. Section showed a dermoid cyst of the right ovary, black and gangrenous, with twisted pedicle. Excision was very simple. The abdomen was cleaned out and drained, and she made an uninterrupted recovery. The points of differential diagnosis were the connection of the tumor with the uterus, the clean and firm tongue, and the absence of that intense, sickening tenderness to point pressure.

This suggests one of the saddest complications of appendicitis—a general septic peritonitis. Fortunately, the terrible mortality fol-

lowing this condition is offset by an occasional life saved by an operation done in time to arrest the process before it has gone too far, and I am glad to be able to record one of four such successes.

CASE IX.—W. L. S., about 40 years of age, patient of Dr. A. M. Barnes, was seen quite late at night, when his attack was nearly forty-eight hours old. He showed the characteristic picture: Coated tongue, slightly distended abdomen and constipation; distinct tumefaction and intense appendical tenderness; temperature 102° and pulse 120. The bowels had been cautiously unloaded. Operation had to be postponed until morning, when the temperature was down to normal, the pulse reduced in frequency, and the distension but slightly increased. This increase was particularly noticeable in the epigastrium. There was, however, an anxious, very sick, almost cadaverous look about the face, and the local tenderness was very much intensified. On opening the abdomen, a quantity of offensive sero-pus gushed out, and the presence of a septic peritonitis, not limited by protective adhesions, was readily recognized. The appendix was firmly glued to the iliac fossa, but unprotected on its upper surface—gangrenous and perforated by the separation of a slough at one point. The organ was dug out and excised, and the toilet of the abdomen carried out by scrupulous wiping of the intestinal coils and parietal peritonæum with gauze pads wrung out of bichloride solution.

Under such circumstances antiseptics can be used without fear in the peritonæum, for its absorptive power seems to be arrested just as it has been proved to be satiated after free douching with salt solution. Douching the cavity under almost any circumstances, and particularly when a septic process is present, has been conclusively shown to be useless as well as dangerous.

A couple of yards of iodoform gauze were packed into the abdomen and the wound partially closed. Improvement was immediate and his recovery rapid. A week later the gauze was removed and the cavity drained with a rubber tube until it filled up to the external wound, when this was freshened and sutured.

I take the liberty of digressing just here to call attention to the value of the pack. Tait's tube drainage is fast losing ground, while his drainage by increased peristalsis is gaining. Miculicz's plan of using an iodoform gauze apron, into which are packed strips of the same material, I find of ever-increasing utility to induce protective adhesions, as a capillary drain, and as a hæmostatic measure. Once this has formed a distinct, practically extra-peritoneal cavity, the

drainage-tube resumes its sphere, for the gauze becomes clogged and dams back discharges.

In a recent case operated for Dr. W. J. Earhart, a large carcinoma of the omentum had dropped down and become attached to a matted pelvis containing pus tubes. At the close of the operation the whole basin was a raw, septic surface. The Miculicz pack was used, and after its removal the cavity was drained and kept clean through a rubber tube.

In another case, operated with Dr. J. P. Lukens, of Wilmington, Delaware, the hæmostatic properties of this plan were well demonstrated. The patient, a lady of 50 years, had a somewhat nodular tumor on the left side of the uterus, with considerable ascites. Just before operation the intra-abdominal fluid increased rapidly, and she showed symptoms of asthenia. On section, about two gallons of fluid were turned out, presenting the appearance of almost pure blood. The relief of pressure was followed by a tremendous hæmorrhage, which threatened to kill the patient on the table. A soft, probably cystic, tumor of the left ovary was made out, from which sprang an enormous papilloma, the source of the bleeding. Universal adhesions rendered the imperatively rapid enucleation impossible. Over four yards square of gauze (iodoform and, when that ran out, sterilized) were quickly packed in, and the abdomen partly closed. She made a good recovery, and there has been no increase in the growth nor any return of the ascites. Whether the plastic process will strangle the papilloma, or whether the mere opening of the abdomen will have the arresting tendency we so often see, time alone can show.

Occasionally nature will come to our assistance and prevent a general septic peritonitis by limiting the infection to some extent, giving the patient a little more grace. The following case illustrates this:

CASE X.—J. W. S., æt. 23, patient of Dr. H. S. Weaver, went safely through an attack of which he had had several. Slight tenderness and tumefaction persisted, but he was well enough to go about the house by the tenth day. On exerting himself a little, he was suddenly taken with severe right iliac pain. When I saw him, there was the characteristic face, tongue, distension, and beginning vomiting, or I might say, bubbling out of fluids. To this should be added a marked condition of collapse. The whole right side of the abdomen was tumefied and dull on percussion, from the rib border to the pelvis, and as far as the median line. Incision showed

the same stinking sero-pus as in Case IX., but the left half of the abdominal cavity was shut off by very soft adhesions and intestinal coils. The appendix was imbedded in a small well-encysted abscess, and was perforated by the pressure of a concretion. The exertion had caused a rupture and the escape of the intensely infectious pus. The cavity was wiped clean and packed with iodoform gauze, and the patient made a good recovery.

Extensive as was the process, if the adhesions did not leak, this would have become a localized abscess which might even have discharged and cured itself. No matter how much of the abdominal cavity is involved, if the process is limited by adhesions, a fatal septic peritonitis is changed to a comparatively safe abscess. Pollard reports, in a recent number of the *Lancet*, the case of a child with an abscess extending from the diaphragm to the pelvis, from flank to flank, and limited by the abdominal wall anteriorly and adherent intestinal coils posteriorly. It had made a vent for itself at the umbilicus, and nature required but a little assistance in the way of drainage to effect a cure.

In the following case there was a similar abscess, but rupture was prevented by rest and careful diet. When pus is once present in or about the appendix the indication for operation is positive.

CASE XI.—J. B., 65 years of age, was seen with Dr. J. N. Mitchell, on the second day of what must have been the last of several attacks. The symptoms were on the wane and rapidly disappeared, leaving a tender, distinctly outlined tumor in the characteristic location. Even the tenderness was almost gone, while the tumor was smaller but still distinct, at the end of ten days, during which time he was carefully dieted and kept absolutely quiet. He refused an operation on account of the improvement. On the day he got up, he took his first full meal, which disagreed, and was followed by vomiting, distension, and rapid increase in the tumor and tenderness. Immediate section showed the appendix attached to the posterior abdominal wall, surrounded by an ounce or two of thick, offensive pus, and firmly encysted by very dense adhesions to the omentum and intestines. It was dug out and excised, the abscess cleaned and drained, and iodoform gauze packed around the opening to shut off the peritoneal cavity. The wound healed by granulation.

CASE XII.—A young man was seen with Dr. Joshua Allen on the fifth day of an attack. The course had been a sneaking one: apparent subsidence of the symptoms; relapses with the develop-

ment of two new points of tenderness and tumefaction, varying temperature and pulse, recurring and severe abdominal pain; gradual distension; complete bowel obstruction, collapse. The abdomen was opened in the middle line, and found full of stinking sero-pus; the three abscesses, one of them containing the appendix, the other two high and low on the left side, were cleaned out and packed; and the peritoneal toilet carefully made. The patient rallied for a time, but died the next day.

Every one who has had much experience with appendicitis has met with these cases. I have felt at times that no operation should be undertaken, and it would be better for the surgeon and for the cause of the proper treatment of appendicitis, if they were left alone. An occasional success, such as those reported by Miculicz, Hartley, and a few others, encourage us to try what is by no means a pleasant duty.

Some English surgeons are skeptical of what they term the American mania for removing the appendix; others, more courteous, consider the disease more prevalent on this side of the ocean. With this and similar cases in mind, I cannot but recall the statement made by Treves, in his work on intestinal obstruction, which he says is the cause of two thousand deaths a year in England. How many of these "obstructions" are the closing scene of a perforative appendicitis, with septic peritonitis, and arrested or reversed peristalsis?

CASE XIII. was operated before the abscess ruptured, or infected the peritonæum. As is very frequently the case, however, it was encysted against the posterior abdominal wall, and had to be evacuated "across" the peritoneal cavity. In spite of this difficulty such cases usually do well, but when left alone are apt to result fatally.

Miss M. M. was seen on the fourth day of an attack, with Dr. C. R. Norton. The belly was distended, the temperature high and fluctuating, the pulse rapid and weak, the tongue flabby and coated, the bowels constipated, and the general appearance that of a very sick girl. There was a distinct, tympanitic tumor in the usual location, which was intensely tender to the touch.

When the abdomen was opened a large mass of adherent intestinal coils and omentum were found about the caput coli. Sterilized gauze pads were packed around the tumor to shut off the peritoneal cavity, and the adhesions separated with the finger, evacuating nearly a pint of characteristic pus. The cavity was cleaned out with peroxide of hydrogen, and then with bichloride solution, and

the appendix, not being readily found, was left alone. Iodoform gauze was substituted for the pads, and the abscess cavity tamponaded with the same material. The extremities of the wound were sutured. Improvement was immediate and continuous. In a week the packing and the protective gauze were removed, and the cavity treated as an extra-peritoneal abscess. Later on the wound was drawn together.

Case XIV. illustrates the simplest problem nature gives us to solve, and, if the endurance of the patient does not give out, she would ultimately effect a cure unaided. Fortunately, such instances are very common, and they only show how much we owe to the ever-watchful omentum and intestinal coils, which pounce on a leak as the indefatigable Dutchman mends the walls of sand that keep dry his otherwise submarine land.

W. A. B., about 35 years of age, had been treated for a number of weeks for rheumatism by a surgeon. Dr. W. K. Ingersoll was finally called in and diagnosed an appendical abscess. I saw the case with him and Dr. R. C. Smith. There was a large fluctuating tumor above the right groin, extending around to the back. This had been noticed for several weeks, and during its growth had worn out the patient with chills, erratic fever, and profuse sweats until he was in a condition that made any operative procedure a serious matter. Parker's incision was made down to the peritonæum, through which an enormous abscess was opened, cleaned out, and drained. A counter-opening posteriorly was necessary. Recovery followed a prolonged convalescence.

In conclusion, let me say that:

The patient's safety depends upon an immediate diagnosis; hours in this disease are worth more than days in almost any other.

To a correct diagnosis must be added an appreciation of the possibilities of the disease, and these become certainties in a very short time.

If such an attack does not show a diminishing tendency in twenty-four hours at the outside, the case is probably one imperatively demanding surgical interference.

Even with subsiding symptoms, peritoneal infection must be looked for.

If general, this will be shown, at first, by increasing distension, particularly noticeable in the epigastrium, by an anxious, sick look about the face, and, usually, by intensified tenderness of the appendix. Operation cannot be done too soon.

If the infection has been localized, there will be tender tumefaction, distinct and persistent, which shows that nature has saved the patient's life, but requires operative assistance. The urgency, of course, is not so great, but exertion, rough handling, increased peristalsis, or even an error in diet may cause rupture.

If rupture does not take place, a slow leakage may occur, which can set up a general peritonitis, very insidious in its course, or consecutive abscesses, both of which conditions are almost invariably fatal. The latter condition can be recognized by the development of other tender swellings, increased abdominal pain, and an intensifying picture of septic peritonitis.

Aside from this, there is the danger of systemic sepsis that may follow any abscess, particularly with such offensive contents.

While I am not quite willing to advise that every case of appendicitis be operated as soon as the diagnosis is arrived at, I am convinced that such a diagnosis makes the disease as much surgical as a suspected fracture of the skull.

PHTHISIS PULMONALIS AS A SEQUEL OF MEASLES.

BY W. J. MARTIN, M.D., PITTSBURGH, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania,
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SEQUELÆ to measles are not so frequent as to scarlet fever. It is rather exceptional for a case of scarlet fever to recover without some sequel, but with measles the exception is to have sequelæ.

Raue says (*Special Pathology and Therapeutics*): "that under homœopathic treatment sequelæ are of very rare occurrence." He also mentions as the most prominent sequelæ, "chronic catarrhal cough and chronic pneumonia, which may end in consumption." Duncan (*Diseases of Children*) says: "Another sequel to measles is tuberculosis. Sometimes it develops very rapidly and intensely as miliary tuberculosis, so that patients never recover enough to leave the bed, but continue to suffer from fever and to cough and emaciate from the time the exanthem disappeared. Generally, however, an interval is observed between the disappearance of the eruption and the first appearance of the tuberculous symptoms. These children get up again and are free from fever, have a good appetite, and the measles are forgotten. A slight bronchitis, however, has remained, and

persists in defiance of the best nursing and uniform temperature, etc. Very gradually aggravations are noticed towards evening, followed by general indisposition, loss of spirits and strength, and with this the cough increases in severity. The emaciation becomes more and more marked, the tuberculous phenomena are soon physically demonstrable, and in most instances rapidly advance to a fatal termination. Should this be arrested the child will for years be prone to bronchitis and experience new tuberculous attacks."

Hartman (*Diseases of Children*) mentions phthisis as one of the sequelæ of measles. Reynolds (*System of Medicine*) says: "Acute tuberculosis or chronic phthisis may occur during the course of the disease, but usually first gives evidence of its existence after the fever has declined. Acute tuberculosis follows measles more frequently than any other of the acute specific diseases, whooping-cough being perhaps excepted." Pepper (*System of Medicine*), says: "Chronic pulmonary tuberculosis is one of the most formidable and frequent sequelæ of measles. It is not an uncommon occurrence that, with the exception of some trivial bronchitis, a patient may apparently recover his health completely, and only after a lapse of time slight daily elevations of temperature, accompanied by loss of appetite and emaciation, first give warning of the impending danger. Granular meningitis or general miliary tuberculosis also frequently follow in the wake of measles, connected in many cases with foci of caseous degeneration in the involved lymphatic glands or unabsorbed pneumonic exudation."

Ziemssen's *Cyclopædia of the Practice of Medicine* says: "It is not uncommon for children, apparently recovered from measles or convalescent, to be seized anew with difficult respiration, and, after a longer or shorter duration of the new disturbance to even die, sometimes of cheesy pneumonia, with or without tubercles; sometimes from general miliary tuberculosis or tubercular meningitis, the causes of which, as it appears, must be especially sought in the cheesy degeneration of the swellings of the lymphatic glands occurring in the course of measles. The tuberculous bronchial glands, in particular, afford a frequent point of origin for tuberculosis of the lungs after measles."

Hennoch (*Lectures on Diseases of Children*) says: "Chronic broncho-pneumonia is undoubtedly the most frequent sequel. In a series of cases it terminates fatally after a number of months, under increasing emaciation and hectic, and we then find on autopsy either chronic broncho-pneumonia, with dilatation of the bronchi

and small pulmonary abscesses, which have been formed by the destruction of the alveolar walls and coalescence of the pulmonary vesicles, which were filled with pus, or more frequently cheesy degeneration of the lungs and bronchial glands. The opinion that measles has a special tendency to the production of tuberculosis depends, as I believe, upon the fact that this disease, like whooping-cough, on account of its frequent complication with bronchopneumonia, especially in predisposed individuals, may give rise to cheesy processes in the lungs, followed by miliary tuberculosis."

Notwithstanding the fact that "acute tuberculosis follows measles more frequently than any other of the acute specific diseases," and "is one of the most frequent and formidable sequelæ of measles," I had never observed, or, possibly, to speak more correctly, had never recognized, a case of this kind until this year, though I have treated hundreds of cases of measles. Could the explanation of this be, as Raue says, "that under homœopathic treatment sequelæ are of very rare occurrence?"

This summer I have had under my care five cases, with a possible sixth, of phthisis pulmonalis, or of chronic pneumonia, following measles, and which it is the object of this paper to report. My first case was that of an ill-nourished child of about 3 years. It suffered from chronic intestinal catarrh due to improper feeding. All of its surroundings were unhygienic. It was taken sick with measles the latter part of April. The eruption developed very tardily, but eventually very well, so that by May 6th I ceased visiting the case, as it was convalescent, and to all appearances required no farther medical treatment. May 15th I was recalled, and found the child not as well as when I dismissed her. There was very persistent rough cough, hectic flush, progressive emaciation, diarrhœa, capricious appetite, and excessive thirst. My treatment produced no impression on the case. It progressed steadily to death, which occurred June 13th, about six weeks from the onset of the attack of measles. I gave this case *ars.*, *ars. jod.*, *psorin.*, *calc. phos.*, and *arg. nit.*, as they seemed to be indicated, the latter on account of the great craving for sugar and candy. I had her also take all the bovine she would.

The next case was a boy of about 5 years, whom I saw first the latter part of May. He had been under old-school treatment for some six weeks. His illness started with an attack of measles, from which he appeared to recover, but in a short time was sick again with fever, etc. They recalled their doctor, who, after a short time,

pronounced the child again well. But as he got worse again, they concluded to change the treatment, and I was called to the case May 21st. The little fellow was very pale, waxy, and emaciated; had a hard rough cough, without expectoration; rapid respiration; no dullness on percussion; bronchial breathing and coarse râles heard on auscultation; temperature, 104° ; diarrhœa; complains much of pain in the stomach, which is aggravated by drinking cold water; is thirsty, restless; worse at night and every other day. Prescribed ars. 3x. The following day, May 22d, the temperature was 100° , a fall of 4° , and in every way the child was better. The ars. was continued.

May 23d, the temperature was up to 104° .

May 24th, " " " 104° .

May 25th, " " " 99° .

May 26th, " " " 99° .

The ars. 3 was given all the time, and the child was improved in every way; and as I wanted to leave next morning for Chicago, I dismissed the case. When I returned home, in two weeks, I found the child as sick as he had been before. Under treatment he improved again, only to again relapse. I now warned the parents of a strong probability of a fatal termination, and for my candor was dismissed the case. I was able, however, to keep informed as to its progress. My successor was an allopathist, who, after a time, was succeeded by another allopathist, and he, in turn, by an homœopathist, upon whom devolved the duty of furnishing the death certificate. The child was sick over two months, steadily going down, but enjoying brief periods of improvement, which, as the disease progressed, became fewer and of shorter duration.

About the same time that I was called to the last case I took charge of a case of whooping-cough that was just getting over an attack of measles. This child and another one that had been similarly affected and died, was under the care of a physician who graduated at a homœopathic college in Cleveland a few years ago, but who now, according to Polk's *Medical and Surgical Register of the United States*, vol. iii., disclaims being an homœopath and styles himself a regular. He had informed the parents of the child that it was useless to give medicines for whooping-cough. His services were dispensed with. Under the influence of the indicated remedies, which were principally ars., cina, and kali sulph., the child got over the whooping-cough and also a very bad diarrhœa, but it did not get well; on the contrary continued to cough, with coarse bubbling

râles heard all over the chest, evening fever, progressive emaciation and exhaustion. In this condition the child passed from my care, and shortly after died.

In the early part of June while I was absent from the city the two daughters of D. E., aged about five and eight years, took down with measles and came under the care of Dr. B., who attended them until my return home, when I was called. I found each taking three remedies in rotation. They were over the measles but had an irregular fever, prostration, diarrhoea, and cough. Under what I considered the indicated remedy in each case they improved, and when apparently well would relapse, the temperature run up, cough increase, diarrhoea set in, etc. Improvement would again be followed by relapse, emaciation and exhaustion progressing steadily until death finally ended the scene. In all these cases a most constant and peculiar symptom was, picking, either picking the nose, lips, or fingers. Cina or arum triph., were confidently prescribed on the strength of this, but without avail. In the last case change of climate was also tried, but it too was without beneficial result.

My last case is to me most interesting, as it differs from the others in this, that the child has to all appearances made a perfect recovery, though from the unfortunate experience I had had, I made a very unfavorable prognosis to the parents. For my candor I was not in this case dismissed, but rather the more strongly adhered to.

The patient was a child twenty-two months old, who had never been sick except with the whooping-cough, from which she was suffering at the time of the attack of measles—though the whooping-cough had not affected the general health in the least. The measles set in July 24th with very high fever and most persistent sneezing; the cough also became much more troublesome. Under belladonna the measles ran their course in the usual length of time. The eruption had been so dense that desquamation followed. The cough remained very severe, and the child instead of feeling and resting better was restless and sleepless and hot, especially at night. The temperature keeping up after the disappearance of the eruption to, from 102° to 104°, sometimes higher in the morning and sometimes higher in the evening, the latter being most frequent. Dyspnoea was very marked, so much so that the baby could scarcely nurse “for want of breath.” The bowels were loose, the discharges being very offensive. The upper half of the right lung was consolidated, the consolidation progressing from the apex downwards. This condition persisted for two weeks after the subsidence of the measles,

when Dr. J. B. McClelland, in consultation prescribed one dose of sulphur 200, to be given on the morning of the day following the consultation, no medicine to be given the night before or the day after. This was done, the temperature at the time the one dose of sulphur 200 was given was 103°. The next morning it was 101°. Improvement in every way was steady so that in one week from the giving of the sulphur the temperature was normal and had been so for two days, the lung was clear, and in a few days I dismissed the case well, except the pertussis. For a week I heard nothing from the child, then it was brought to the office sick again. They thought it had taken cold, the cough was worse, with yellow expectoration, yellow nasal discharge, fever without thirst, and upper part of right lung again consolidated. Temperature 102°, the child wants to be out of doors all the time. I prescribed pulsat. 3, a dose every two hours, also a teaspoonful of pure cod-liver oil three times a day. Under this treatment the child improved rapidly, and in a week the temperature was normal and remained so, appetite restored, cough much less, but there was yet dulness on percussion over the upper right lung. One dose sulphur 200 was given as on the former occasion. After waiting for three days and no improvement being manifested, I gave one dose sulphur 30 trit., which was followed by improvement, the lung slowly but steadily clearing up from below upwards. The child was then taken to the country, and I am informed that its health is now perfect.

I have come to look upon cases of measles where the temperature keeps up after the subsidence of the rash, or where the temperature rises after having dropped to or about normal, as of the utmost seriousness. They may have no cough whatever or a very slight one, but are apt to go into a general phthisical or wasting condition characterized by two constant features, viz., irregularly elevated temperature and progressive emaciation. With these there may be any number and variety of other symptoms. The illness is usually very protracted and the termination almost invariably fatal.

When in attendance at the World's Congress of Homœopathic Physicians in Chicago last June, I was requested by Dr. Webster and his wife, of Dayton, Ohio, to go with them to Englewood to see their sick grandchild. This was a case of what had been a healthy and beautiful little girl of seven years. She had measles in April, and has been sick ever since with what at various times was considered rheumatic fever, gastric fever, typhoid fever, etc. There were periods of aggravation and periods of amelioration in her con-

dition, with a remittent and intermittent type of fever. When I saw her she was enjoying one of her periods of amelioration and fall of temperature, but emaciation and exhaustion were very marked. In reply to a letter of inquiry, Dr. Webster writes me, under date of Sept. 15, 1893: "Our little granddaughter still lives, but has had a hard time of it. The prospects now are that she will recover, although for many weeks they despaired of her life. She is a skeleton." This child has been sick now for over six months, and while I sincerely hope that their fond expectations may be realized, I am of the opinion that this is a case of phthisis of the kind I have described, and that recovery is not to be expected.

I can suggest nothing in the way of explaining why some cases of measles terminate in this manner. It is not due to any constitutional taint, as children of the most healthy parents may go this way; and, on the contrary, I have seen children of scrofulous, consumptive and syphilitic parents pass through measles of severe type, and recover without a sequel of any kind. Neither can I suggest anything in the way of treatment to prevent patients with measles from going into this condition, except to again repeat the words of the venerable and honored Raue: "It is but just to remark that under homœopathic treatment sequelæ are of very rare occurrence."

HYPODERMIC INJECTIONS OF MORPHIO ATROPINE IN STRANGULATED HERNIA.

BY F. H. PRITCHARD, M.D., WEAVER'S CORNERS, HURON CO., OHIO.

A FEW nights ago I was called to an old gentleman of some sixty years. He had suffered from a scrotal hernia of the left side ever since the war of the rebellion, it originating in his being kicked in the abdomen by a fellow-soldier. He usually kept it in place by a truss, but the one he was then wearing fitted him badly and it would occasionally slip from the pad and come down. That evening it had escaped from the ring, slipped down into the scrotum, and formed a tumor of the size of a big Bologna sausage, of four inches in length. It was extremely painful to the touch. He complained of severe pains in the abdomen, which radiated down into the tumor; nausea, etc. His wife had tried to reduce it by manipulation, she being quite expert in this way, and having reduced it be-

fore, at every time by application, warm compresses, etc., but in vain. I found it impossible to replace the contents of the sac after some fifteen minutes' manipulation, with various changes of position of the patient, accompanying my attempts to reduce by alterations in the position of his leg and thigh. I then bethought myself of a procedure of which I had read somewhere, but the journal and author I cannot cite. He recommended subcutaneous injections of atropine to induce dilatation of the ring. I injected a combination of morphine and atropine, one-fourth of a grain of the former and one one-hundred and fiftieth of the latter, into the immediate vicinity of the ring, sat down and waited for five minutes by the bedside. I heard a few slight gurgling sounds, and on placing my hand upon the tumor I found it slightly reduced in size. I then began taxis, and in two minutes the gut was replaced in the abdominal cavity and the patient was free from all pain. He put on his truss, walked down stairs, and went to sleep. The next morning he was feeling well, beyond a slight dizziness and dryness of the throat. His pupil was normal. I preferred to give the combination of morphine and atropine, as I thought it would be fully as efficacious as the atropine alone, and they being antidotes, the one would guard the other and prevent disagreeable after- or side-effects. I report this little incident, as I cannot find any literature on the use of this drug, atropine, in strangulated hernia, and hence thought it worthy of recording.

NEURASTHENIA AND ITS ORGANIC COUNTERPARTS.

BY WESTON D. BAYLEY, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania,
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THE group of symptoms known as neurasthenia, has given rise to a vast, and rather acrimonious literature. Many deny its existence as a disease, maintaining that the condition is always symptomatic of some perhaps unfound, but tangible lesion.

In the present state of our knowledge, however, we practically have to admit neurasthenia to the dignity of a distinct disease, and we have to compare it with multitudinous affections which give rise to symptoms aptly termed neurasthenic.

At the very outset a definition is wanted. Definitions and definers

have been at variance, but here it will be regarded as a condition of instability of nervous function, resulting in a variety of non-convulsive symptoms, varying according to the portion of brain or cord affected, and dependent upon some nutritive alteration in nerve tissue. A steady drafting off of nerve force in a perverted manner will cause more or less constant abnormal phenomena; irregular unnatural outbursts of it being responsible for the more acute symptoms.

The normally conducted functions of the nervous system when considered in detail, are wonderful indeed to contemplate. The almost continuous influx of sensory messages, assorted, arranged, and modified in the basal ganglia, each rapidly sent to its proper terminus, perhaps from thence referred through the associating fibres to several different centres for modification, the quick and appropriate motor response. This, with or without consciousness, according as the message is, or is not, referred to the cortex of the anterior brain. Consciousness is the accumulation or result of these sensory impressions; and yet, the majority of physical functions are performed without its influence. Responses to sensory stimuli which are always formulated and definite, in the course of evolution soon become automatic. The beginner who awkwardly fumbles the piano keys, becomes the real automaton who plays accurately while he converses with those about him.

As these various functions of the brain are relegated to sub-conscious or automatic sub-stations (if I may use the term) in the nervous system, and as the cerebral and conscious functions become more and more complex in their character (as is the case in man), it is as natural to expect greater tendency to forms of nervous perversion, as it is to look for more accidents on a great railroad system when its lines are extended and its traffic increased.

It is therefore readily to be imagined that slight nutritive alterations, which elsewhere would result in no symptoms whatever, will produce, in a tissue whose duties are so intricate, considerable functional change.

A perversion, then, of any of these functions, be they conscious, sub-conscious or automatic, in the absence of tangible organic disease, constitutes a condition which we are compelled to recognize and properly term neurasthenia.

Now while we have endeavored to show that neurasthenia is a legitimate term, and describes an actual condition found in practice, a diagnosis of this trouble should be made with the greatest reluc-

tance. Organic disease of the most varied character, either frank or concealed, in nervous tissues or non-nervous organs, will produce a collection of neurasthenic symptoms very hard to differentiate from the idiopathic affection. As with kindred terms—biliousness, malaria, etc., there is danger of its becoming a makeshift for ignorance or carelessness. Every organ must be interrogated, every nook and corner in the body searched for evidence of organic, or grosser functional disease.

True neurasthenia may have a general or a local expression, and according to the manner in which the symptoms become manifest, it is given a local name; thus, we hear of cerebral, sexual, spinal, gastric, abdominal and other neurasthenias. Some cases may have a purely local beginning, but sooner or later the whole nervous system is implicated.

The symptoms are general and local. An average case is about as follows: A man from overwork or a woman from worry, gets into a condition of high nervous tension—like a stringed instrument screwed way up above pitch—becomes gradually unable to endure as much as formerly—becomes easily fatigued upon exertion; often complains of backache and spinal tenderness. The disposition is altered; the patient becoming despairing, despondent, peevish and irritable. He thinks that he has some grave incurable disease. Paræsthesiæ and various numb feelings are complained of. The sexual function is diminished and the sexual organs become irritable. The urine is often turbid and there is a deposit of urates, oxalates and phosphates. Insomnia often adds to the burden of misery. Any of the viscera may share in the trouble, and give a definite tendency to the symptoms. Curious mental symptoms often arise. The perusal of quack literature and newspaper accounts of wonderful cures sinks the patient still deeper in the mire.

The sexual neurasthenic is of all others the poor dupe of the quack and medical humbug. Without these cases, volumes of serio-comic literature about the science of life, or lost manhood restored (sent in a plain envelope on receipt of a two cent stamp) would have been profitless writing. Of all mankind the sexual neurasthenic is the most gullible, and hardest to manage.

These poor creatures have symptoms which at once divide themselves into two kinds: Objective—Lack of copulative power, nocturnal, and very rarely diurnal emissions. Subjective—Broodings over their symptoms and morbid fancies concerning them.

There is no need of detailing the symptoms; but there is need of

caution in mistaking a purely functional sexual neurasthenia for one of organic disease of the brain, or cord on one hand and the sexual organs on the other.

The early stages of some cerebral degenerations are accompanied by sexual perversion and irritation, together with general symptoms which might be considered neurasthenic. Locomotor ataxia has been mistaken for sexual neurasthenia; but a very little care would have prevented this error.

Local sexual diseases can be confounded with neurasthenia, and are capable, by directing the patient's solicitous attention to the sexual organs, of causing neurasthenic symptoms. Thus, one patient became neurasthenic from an imagined seminal loss, which proved to be simply mucous from a vesical catarrh. Strictures of the urethra, prostatic diseases, prepucial abnormalities, atrophy of the testicles and sebaceous accumulations are only some of the local causes of symptoms resembling a true sexual neurosis.

CEREBRAL NEURASTHENIA is more apt to affect a different class of people. Sexual neurasthenia is likely to manifest itself in those of but moderate education, but this is an affection of the intellectual.

Practically, it occurs most often in those whose brains develop out of proportion to, or at the expense of, their bodies. An attempt even to generalize the symptoms of such a one would expand this paper to immoderate length. Mental and physical fidgets is put upon the generic symptom, and this term best describes the nervous, restless manner, the pains and aches, the fads and the fancies, the matchless courage and the unaccountable fears, the solitary broodings, the flights of genius to which the cerebral neurasthenic is liable. Sometimes the trouble is highly specialized, as in atrophobia, opophobia and so on, but here the condition encroaches on the region of true mental disease.

Nearly all chronic diseases are capable of causing general neurasthenic symptoms. Bright's disease, phthisis and malignant growths, by impairing the quality of blood; heart affections, by disturbing its circulation. Abdominal affections are very apt to cause symptoms of mental depression, just as a neurasthenia is apt to be followed by visceral disturbances below the diaphragm. It is often difficult to distinguish cause and effect.

There is nothing distinctive in a neurasthenic headache; it may be local or diffuse, of varied onset and varied character. A diagnosis must be arrived at by exclusion of other causes of headache and by a study of concomitants.

I have repeatedly observed not only headaches, but genuine neurones, to be dependent upon eye-strain, especially the milder forms of astigmatism, and a trifling correction may promptly remove symptoms which have stubbornly resisted all other treatment.

Spinal tenderness is a common symptom in the disease under consideration, but pain in the spine may also result from vertebral disease, as caries, rheumatism, arthritis deformans, etc.; in muscular affections, as myalgia and muscular rheumatism; in diseases of the spinal cord and meninges, as in meningitis, new growths, tabes, etc. Pelvic disorders are often accompanied by pain in the back. All these must be considered before pronouncing a given case of backache to be neurasthenic. It has been the object of this paper not to enter into a detailed account of neurasthenia, but to awaken greater diagnostic acuteness in those of us who have entirely too many cases of chronic nervous prostration.

Treatment of Neurasthenia.—The crucial test of business tact and talent in a physician is his ability to hold his neurasthenics. They are, as a rule, a wandering class, going from this and that to the other doctor, finally landing in *your* office with that indescribable something in their manner which at once impresses upon you the fact that they have been “the rounds” of the doctors.

The first principle of treatment is to gain their confidence. A thorough examination at the outset not only leads to a better understanding of the case, but it also makes the patient feel that you are going at him in good earnest. Great patience is required in the answering of their numerous questions; or, again, many are in the habit of answering their own questions, and thus saving you the trouble of doing so.

Mental symptoms, such as dread of particular things, are best overcome by exposing them to the object of their dread. Thus, a hale and hearty neurasthenic developed an unaccountable dread of knives. This man, although of splendid physique, would turn pale, tremble, and break into a cold perspiration should he have to approach a butcher stand with knives upon it. He was directed to purchase a number of sharp knives and keep them as much as possible as constant companions. This variety of the trouble, although classed by alienists under a different caption, is often truly neurasthenic.

The second principle of treatment is to look after bad habits—sexual habits, dietetic habits, mental habits, bodily habits, when bad, all tend to foster or support the disease. A change in the direction

of thought is useful; the study of a cheerful author or the taking up of a prescribed line of reading directs the thoughts into new channels and diminishes the tendency to introspection (which is another bad habit these patients have.).

Spirituous and malt liquors and the excessive use of tobacco must all be interdicted. Many cases have in their make-up rational symptoms selective of a given remedy, but in no other disease is a strictly homœopathic prescriber led into greater difficulty. Symptoms are often random and fleeting—one set to-day, another to-morrow, and a totally different kind the day after—so that one could have in rapid sequence indications for a third of the materia medica.

There are some medicines which prove clinically of especial importance.

Iodide of Arsenic (2x made fresh).—Cases resulting from overwork. They are easily fatigued, the appetite is poor and digestion imperfect. Symptoms of general anæmia (chin., ars.).

Avena sat. 8 gtt. V. t. d. acts very satisfactorily in cases of cerebral neurasthenia from brain work or worry. There is a neurotic depression of the circulation resulting in coldness, etc. Erythroxy-lon coca is useful in similar cases.

Phosphoric Acid.—Prostration, weariness, loss of appetite, mental depression and sweats.

Fluid extract salix nigra (gtt. xv. +) has proven of great service in some stubborn cases. Its action is particularly upon the lower spinal cord. Pains in the back and the obstinate pelvic pains of neurasthenic women have often been quickly relieved; irritable conditions of the sexual organs.

Staphisagria, given on its well-known indications, is also a remedy of considerable value in these sexual neurasthenics.

Strychnia phosph. 2x is useful in cases of spinal exhaustion with dorsal pains. They are sleepless and have cold, sweaty extremities.

Physostigma has many cerebro-spinal symptoms which would suggest its use in neurasthenia. I have never tried it.

Spigelia has helped a case wherein there was a great dread of knives and sharp-pointed instruments.

Weir Mitchell's treatment with rest, massage, electricity and hyper-feeding is not practically applicable to the majority of cases. It is, doubtless, of great value, and in bad cases, or when the patient's circumstances will permit, it should not be untried.

RED THREADS.

BY Z. T. MILLER, M.D., PITTSBURGH, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania,
September 21, 1893.)

RED threads attest the genuineness of money, why should not the same be said of *materia medica* which is more valuable than money? In my last paper to this bureau I suggested the utility of every one recording the verifications made during the year, the same verifications to be named the "Red Line" series. This series would seem to me to be a revision of *materia medica* in a line tending to complete reliability without the accompaniment of division and substraction which seems to be the aim and object of all who attempt to correct the lines of a structure so monumental, that few of us comprehend it. Pathogenesis is a solemn thing; men who make or mar it, incur a responsibility that is measured only by life and death. It is the ballast that steadies the ship of health through the minor storms of life, till the craft strikes the cyclone that engulfs the ballast, keel and rudder alike. Such a cyclone strikes nearly every craft, such a catastrophe overtakes the majority when the voyage is wholly incomplete. Whether from the inherent fault of the ship or the poverty of the medical helmsman, or the inherent weakness of both, certain it is, that no man's sun should be eclipsed in the morning, the noon or the evening of life, not until the shadows strike their longest lengths toward the east and the twilight deepens into the canopy of night, and man sinks beneath it into that wakeless rest of dissolution from age. Nothing short of it is the business of medicine. This "consummation most devoutly wished," should be forever pictured in the minds of *materia medica* makers. Is the standard too high? is it possible for homœopathy to attain it? These questions you may answer yourselves.

In this paper I shall not make *materia medica*, or criticise that made by others. Rather will I give the weight of my experimental evidence in confirmation of that given us for verification.

While what follows does not begin to compass all the good results I have observed, they do, in modest degree, cover ground that is not too often travelled.

SYMPTOMS.—Pain in right leg from point of exit of sciatic nerve, felt only when moving the limb or when sitting > lying down,

dioscorea. After a continuation of eight weeks with morphia in every possible manner in connection with electricity, this pain was relieved and remained so by *dioscorea* 200.

SYMPTOMS.—Eyes feel as if projecting with a sensation as if a thread was tightly drawn through the eyeball, backward into the middle of the brain, *Paris quad*. This was the first and last time this symptom presented. It was promptly cured by the drug.

SYMPTOM.—Salt rheum on arms and hands, red, raw, burning; moist or covered with thick crusts. Deep and bloody rhagades on hands; thick crusts worse during winter, *petroleum*. This case looked in beginning like a rhus poisoning. The hands and arms to near the elbows were red, swollen and covered with hundreds of little blisters filled with opaque fluid. Itching, burning, < when exposed to air or wet with water. *Rhus*^{cm} did not relieve. When the swelling began to subside, thick crusts with deep cracks across the knuckles and back of hands bleeding, coupled with the fact that *petrol.*^{cm} relieved her son of foul smelling footsweat, led to petrol. in this case with an improvement that was steady. One dose of *petrol.*^{cm} every five to seven days for three weeks has removed the whole trouble save a little roughness of skin. A former attack lasted over three months under other treatment.

An elderly lady with a red rash upon the hands and arms, subtended by deep bleeding cracks. The face, neck, and scalp a red raised continuous rash with scaling epidermis. Great itching, < exposed to air and water, no cracks on neck or face, was wonderfully relieved by *petrol.*^{cm}, one dose every seven to fourteen days. These cases verify the symptoms of petrol. first quoted.

SYMPTOMS.—Tonsils enlarged, the face of each covered with a patch of white membrane, the size of membrane about that of the thumb-nail. Tongue furred white. General fever. Cheeks fiery red, *ferrum phos*.

This was what promised to be a case of diphtheria, but was stopped immediately by *ferrum phos*. 200. In twenty-four hours the patches had disappeared, the fever subsided, the patient, a girl 14 years, going on to rapid recovery. The coating on the tonsil was not a follicular exudate, it was a continuous membrane. Pain, heat, swelling and circumscribed redness over seat of pain are good indications for *ferrum phos*. Rheumatism with these points has yielded quickly, so far as pain is concerned, to *ferrum phos*. Circumscribed redness as against the diffuse redness of aconite and bell., make the *ferrum phos*. case. I think I can safely say that the 200th potency

will do better than the lower potencies. In infantile pneumonia it is useful when the circumscribed red cheeks, labored breathing, general fever are present, without the thirst and restlessness of aconite or the nervousness of belladonna.

SYMPTOMS.—Inflammation in right groin, presumably typhlitis, with spasmodic painful pressure in that region as if gas were pressing against an obstruction, relieved by passing gas per anum. Feeling of fulness in abdomen, *natrum sulph.*

These symptoms of *natrum sulph.* have been found so reliable that I have ascribed two cures of inflammation in the region of the cæcal valve to it. Two other cases where the pain was quite constant in that region, unaccompanied by febrile action, and relieved by passing gas, have been cured by the same drug. The two acute cases were in females; the menses appeared almost immediately after taking the medicine. The 200th potency was used.

SYMPTOM.—A feeling of weight in the anus like a heavy ball, *sepia*. This symptom occurred in a young woman who had been recently confined and was experienced while lying down. After the exhibition of *sepia* 30, this symptom disappeared immediately.

SYMPTOM.—"Vomiting of water as soon as it became warm in the stomach," *phos*.

A lady far advanced in pregnancy complained of water-brash, raising of sour water, worse shortly after drinking water, *phos*. 200; the husband assured me the medicine acted like a charm. It is necessary to emphasize the necessity for the prosecution of such work as is here outlined. At the recent meeting of the World's Congress in Chicago, no less a person than Timothy Field Allen pronounced the unreliability of our materia medica and Conrad Wesselhoeft seconded the assertion in no uncertain tones. That vast body of men who have, do and will practice the healing art, using the manner and the means of Hahnemann, there learned that the means, if not the manner, are questionable and need reformation. They listened to the damnation by faint praise of work upon which a temple of pride had been erected, they saw toppling the superstructure that symbolized a life's best effort, because the foundation work was pronounced sand. The whole system was cast into doubt and the lawmakers and the prophets proclaimed it. No wonder that the sandy-haired man from the west (I wish I knew his name) mounted the platform and demanded to know what we had been doing, that after nearly one hundred years we were still possessed of materia medica that was unreliable. Why credit ourselves with superiority

of practice or vantage in mortality rate. If our medicines are myths the deluded people who confide in us *recover*, they are not *cured*. Again I say that it behooves every one of you to discover the "red threads," so that homœopathy shall be above suspicion and not traduced in the house of its friends.

ON THE COEXISTENCE OF PHTHISIS PULMONALIS AND VALVULAR
DISEASE OF THE HEART—AN ARRAIGNMENT OF FLINT'S
PLEA OF INCOMPATIBILITY.

BY EDWARD R. SNADER, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania,
September 19, 1893.)

AUSTIN FLINT, SR., some years since, announced to the medical world that lesions of the valves of the heart and active phthisis pulmonalis were incompatible. This view, coming from so eminent and careful a man as Flint, whose clinical keenness and powers of observation were unquestionably great, led to a general belief in the correctness of the assumption of the incompatibility of the two diseases, and a confidence in the prophylactic power of valvular lesions against the development or continuance of phthisis. The idea of incompatibility became almost axiomatic. Really, the belief in the antagonism of the two affections, or at least in the prophylactic influence against phthisis pulmonalis of an existing or acquired valvular lesion, assumed something of the character of a clinical law. This was the general impression that was retained in my mind, at least, in the earlier years of medical reading and practice.

Many were the learned and lame explanations of the possible *rationale* of this incompatibility—learned, because some able writers offered explanations for the occurrence of latency in phthisis from the presence of valvular lesions; lame, because none of these explanations, however elaborate and ingenious, really presented a reasonable solution of the cause of the supposed immunity or prophylactic influence against consumption from the presence of valvular lesions of the heart.

Young as I then was in medicine, I believed I had a right to think for myself, and a right to draw my own conclusions from stated premises. Flint's observations were correct, I believed. He simply stated the results of his personal experience. Flint observed.

Others explained. The explanations, however, failed to throw any light upon the cause of immunity satisfactorily, to my mind, at least.

A little over eight years ago I observed my first case of active consumption in a patient suffering from valvular heart disease. Here seemed a direct contradiction of Flint's law. However, this discovery did not greatly disturb my mental calm. I was certain, metaphorically speaking, that "one swallow did not make a summer." I could readily understand that few laws in medicine could be of such absolute universality in application that no deviations could occur. I did not see that one exceptional case, from especial environments possibly, could invalidate the truth of a general proposition. It rather appeared to me to be the exception that proved the rule.

However, as the days and weeks wore on in a busy dispensary practice, cases of active phthisis pulmonalis in which were found valvular lesions became more and more numerous. When I had noted quite a number of patients in whom coexisting heart and lung lesions were discovered, the conviction began to dawn on me that possibly Dr. Flint's observation had covered an exceptional series of cases, and that after all the general conviction of the medical profession that the presence of valvular heart disease was prophylactic against or preventive of serious and fatal inroads of consumptive lung lesions, was a grave error—an error, too, that led to laxity in therapeutics and to favorable but false prognoses in cases in which the two diseases coexisted.

With the lapse of time the conviction that Flint's proposition was an erroneous one became firmly fixed, and is the result of rather extended observation and no inconsiderable clinical experience.

I have frequently seen phthisis pulmonalis arise in individuals in whom I had previously diagnosed cardiac valvular lesions. I have seen no break put upon the progress of the malady by reason of the presence of the valvular disease, and have noted that these patients crossed the "Great Divide" just as did other patients who did not possess the prophylactic valve lesions.

These cases taught me two truths—first, that consumption of the lungs could arise in the presence of valvular lesions; and second, that disease of the heart valves was no barrier to the typical progress of the malady.

I have seen, in my private and consulting practice alone, about forty cases, in which active phthisis pulmonalis and valvular lesions of the heart coexisted. In all but three of these cases the con-

sumptive process gave rise to most of the symptoms, and the lung symptoms were the chief source of complaint. In some cases, however, without very decided objective signs of rupture in the compensation, the heart's condition was accountable for part of the picture formed by the symptomatic phenomena. In one of the forty noted the phthisis became latent, in two death occurred in consequence of the valvular lesions before the pulmonary disorder had advanced far enough to in itself cause death.

While I have lost sight of many of these patients, of my own personal knowledge, I know that ten deaths occurred directly from the general asthenia resulting from advanced consumption, the heart participating only in the universal weakness and the valvular lesions contributing in no specific way to the deaths. In one of these cases, however, seen in consultation two weeks prior to a fatal termination, the discovery of a valvular lesion enabled me to stop in fifteen minutes a hæmorrhage that, either actively or passively, had been in progress for two weeks unchecked by the usual remedies. It was a cavernous case, in *extremis* almost, and cardiac tonics, given on the assumption that the reflux of blood through the incompetent mitral valve kept up the hæmorrhage, soon stopped the bleeding.

I have seen four cases of fibroid pneumonia arise in patients suffering from mitral lesions, and the production of fibrosis seemed to me perfectly explicable upon purely mechanical grounds. An unusual quantity of blood escaped into the lungs in consequence of the imperfect valves, thus congesting the pulmonary tissue. As a result of irritation and hypernutrition (possibly) there followed proliferation of the inter-lobular connective tissue. The fibroid process thus initiated subsequently contracted, and the fibrosis was complete and confirmed.

These latter series of clinical cases taught me three other possible truths :

First. That death can take place from phthisis pulmonalis, the heart valves being organically affected.

Second. That a valvular lesion, by reason of the mechanical derangements wrought by defective orificial or valve lesions, initiates the tissue changes that inaugurate at least one form of lung disease, viz., pulmonary fibrosis.

Third. That instead of phthisis pulmonalis becoming latent in the presence of valve disease, in all or nearly all cases (as Flint's observations would have led us to believe), the occurrence of such latency is of extreme rarity.

These conclusions had become part of my belief concerning the co-existence of the two diseases, and, while I was outspoken to students and others regarding my convictions, I have heretofore made no consecutive effort to demonstrate the truth of my position by statistical research or by original compilation of cases observed by myself. In the preparation of this paper, however, I ran over my records in the Heart and Lung Department of the Hahnemann Medical College Dispensary (Philadelphia) to see in what degree my views were supported or negatived by cases there recorded. I shall now present some cases and some figures:

FROM AUGUST 24, 1888, TO FEBRUARY 24, 1893 (ABOUT FIFTY-FOUR MONTHS).

Number of cases of phthisis in which there is no record of the condition of the heart,	846
Number of cases in which the condition of the heart and larger bloodvessels is recorded,	103

CHARACTER OF LESIONS IN THE ONE HUNDRED AND THREE CASES RECORDED.

Mitral regurgitation,	55
Mitral stenosis and regurgitation,	12
Aortic stenosis,	3
Aortic stenosis and mitral regurgitation,	5
Aortic stenosis and pulmonary stenosis,	1
Aortic stenosis, tricuspid regurgitation, mitral stenosis and regurgitation,	1
Aortic stenosis and regurgitation, mitral stenosis, and regurgitation,	1
Pulmonary stenosis and mitral regurgitation,	2
Pulmonary stenosis,	1
Pulmonary stenosis (congenital),	1
Pulmonary stenosis, aortic stenosis, and mitral regurgitation,	1
Intra-ventricular (mitral),	2
Mitral regurgitation with pericarditis,	1
Murmurs at all orifices and valves (definite lesion not diagnosed),	4
Cardiac atheroma,	1
Fatty degeneration,	3
Dilatation of the heart,	1
Aortitis (sub-acute),	1
Dilatation of the aorta,	1
Hypertrophy of left ventricle.	2
Hypertrophy of right ventricle,	1
Hypertrophy of both ventricles,	1
Irritable heart (functional),	2

I want to say that these figures are not a case of special pleading, not a case of making "the punishment fit the crime." I have given you plain, simple unvarnished facts. Had I endeavored to prove statistically the correctness of my proposition as to the frequent coexistence of

heart and lung lesions, I am sure I could have increased the heart side greatly, for in many, very many of the cases of consumption, the hearts were not examined at all. In the rush of dispensary work simply enough physical signs of consolidation or excavation were obtained to justify a rational diagnosis of phthisis. In cases where the diagnosis of the valvular lesions seem elaborate the subjects were thoroughly and minutely examined before classes of students. It was only exceptionally that very minute examinations were made in the general run of patients. I think, therefore, the figures given will be more valuable as proving my main propositions—that valvular lesions are not prophylactic against phthisis, and that if phthisis occurring in a patient with valvular disease the phthisis does not tend to become latent—than if I had prepared a specially studied series of cases on the subject.

I do not purpose drawing percentage conclusions from the figures I have presented. I think figures will lie, under certain circumstances. My design has been simply to present a sufficient number of figures to reasonably negative the idea of the prophylactic effect of valve lesions against phthisis, so prevalent in the professional mind, and to disprove the view of incompatibility, and affirm with emphasis the exact converse of antagonism—namely, the frequent co-existence of the two diseases.

When I tell you that while searching for these statistics I examined the record books page by page and recorded the results on the backs of prescription blanks, and found that for a long period of time (on comparing separate slips) no coexisting lesions were noted, while another slip of paper would show that, extending over a comparatively short period of time, valvular lesions would be one to five (one case of phthisis complicated by valvular lesions to five of ordinary phthisis), you will fully understand why I intimate that figures will lie under certain circumstances, and appreciate the force of reason for not drawing conclusions as to the ratio of coexistence of the two diseases compared with uncomplicated cases of phthisis pulmonalis. Had I taken statistics only from the period of time that apparently proved the points I am attempting to make, my position, theoretically at least, would have been much stronger than those I have presented, covering a more extended period of time. My object, however, has been to discover the simple facts and truthfully record them, and to draw the conclusions that legitimately follow a study of the figures.

I shall now attempt a brief analysis of these figures. Of the

cases of phthisis pulmonalis tabulated three are recorded as being latent (one in the case of congenital pulmonary stenosis), one as acute tuberculosis, one as cavernous, and three as in the incipient form. In the others no mention has been made as to the stage or state of the disease, but the simple diagnosis of phthisis pulmonalis is recorded.

It will be seen, too, by a study of this tabulation of records, that of 949 cases of consumption of the lungs seen in dispensary practice during the period of time mentioned, the condition of the heart is recorded in 103, and that of the 103 cases a definite diagnosis of valvular or orificial heart disease was made a matter of record in 84 cases. Of these 84 cases 3 are noted as latent. Are these 3 cases sufficient to justify the assumption that valvular lesions caused the latency? I trow not. In both my private and dispensary practice I have observed cases become latent which had no valvular lesions, and have seen also patients in whom phthisis existed alone and phthisis and valvular lesions coexisted, who enjoyed variable periods of latency. I cannot say whether, later, these 3 cases became active or not, nor can I determine whether the other 81 cases became latent. It is next to impossible to follow up a big list of dispensary patients. However, I draw here upon my experience in private practice, and reiterate the statement made previously of 10 deaths from phthisis in which the latter disease was associated with valvular lesions. I do not state that consumption may not become latent in a patient suffering from a valvular malady, but I do affirm that, inasmuch as latency occurs without valve lesions, it is an incorrect inference that the latency was directly due to the presence of the heart disease alone. Taking all points into consideration, I believe I am fully warranted in drawing the following conclusions:

That organic valvular diseases of the heart do not act as a prophylactic against the development of phthisis.

That when phthisis attacks an individual suffering from heart disease, the valvular lesion does not materially alter the clinical course of the lung malady.

That, for reasons connected with the mechanics of the circulation, a diseased state of the heart openings or valves is far more likely to favor the production of conditions predisposing to phthisis than to prevent its development, and hence that consumption of the lungs, already established, is more likely to be favored than retarded in its course by the presence of valve lesions.

That, theoretically, the conditions induced by heart defect (viewed

from a narrow standpoint) ought to favor the induction of fibrosis, and, by virtue of the fibroid change, bring about a cure of the lung disease; but that a consideration of *all* the pathological factors present in the lung parenchyma as a resultant of the abnormal condition of the openings or curtains in the heart (the untoward afflux of blood) would rather favor lung breakdown than retardation or cessation of the lung lesion.

That, practically speaking, fibroid change does not cause latency of lung lesions consequent on valve changes, that latency occurs without the presence of narrowed openings in the heart or distortions of the valves, or, at least, the available statistics do not seem to make such a position tenable.

That Dr. Flint's observation of cases of latency were doubtless correct as to fact, but the general conclusion drawn from the coincidental observance of an exceptionally fortunate series of consecutive cases was incorrect.

That clinical laws should not be formulated without extended and extensive observation.

SEROUS MENINGITIS.—Prof. H. Quincke, of Kiel, admits the existence of a serous meningitis of which he has observed 14 typical cases, in adults and children. It is not of microbic origin and has nothing to do with purulent cerebro-spinal or tuberculous meningitis. It is due to traumatism of the head, alcoholism, and certain infectious diseases, especially typhoid fever, pneumonia and mental overwork. It is a disease of children, pre-eminently, though it was also seen in adults up to thirty. The chronic form is more frequent in grown persons. Acute exacerbations are also not infrequent. Fever may be present or absent and, when present, it is rarely high but is irregular and there is not a parallelism between it and the other symptoms. Headache, with stiffness of the neck though less intense than in the tuberculous form, is present but is more diffuse or sometimes frontal or occipital. It may be intermittent or continuous. Consciousness is only disturbed some days after its beginning, more slowly than in the purulent form while it may be associated with delirium and somnolence, but it does not become persistent and deep except in the fatal cases. As in purulent meningitis there is hyperæsthesia, some under the form of articular pains in the shoulders. Hemi-paresis of the face, paresis of the ocular muscles, and vomiting are frequently remarked. The pupils react slowly, sometimes being unequal, but rarely presenting considerable contraction or dilatation. A rare symptom is optic neuritis from passive congestion, only setting in usually after several days have passed. It is the last to disappear. In some cases it is the predominant and only symptom of the disease. The affection being due to compression rather than to a destruction of the brain substance, the symptoms vary in their intensity from day to day. It lasts from one to several months. It may end in recovery or death. The chronic form is either severe or slight. In the chronic form the symptoms are less pronounced and resemble those of tumors of the brain, with general disturbances of motion and mind which may last for years. In slight cases it may be confounded with neurasthenia. The differential diagnosis between tuberculous, purulent, serous meningitis and tumors of the brain is sometimes very difficult. It must be based upon a careful examination of the patient, his antecedents, the presence or absence of tuberculosis in other organs and especially the variable character of the symptoms, from augmentation or decrease of the intra-cerebral pressure.—*La Semaine Médicale*, No. 51, 1893.

EDITORIAL.

EXCESSIVE LEGISLATION.

By many, legislation is viewed as a panacea for all ills, but unless we are prepared to hold that any and every abuse occurring in a community is a legitimate subject for legislative enactment, we must admit that we may have too much law-making.

Under a government avowedly paternal in character we may expect to find its citizens regarded as minor children, whose comings in and goings out are regulated by definite and minute enactments, and whose personal liberty is on all sides hedged in by quite impersonal limitations. But in a country professedly under a republican form of government, we should find each citizen a law unto himself, restricted in the exercise of his personal liberty only by considerations for a like freedom on the part of his neighbor. The only right of such a government to pass laws has been delegated to it by the citizens who form its component parts. There is no divine right of rule here, but only a quite humanly derived right, as a whole, to protect each individual in his life, liberty, and pursuit of happiness.

When such a government, therefore, begins to say by legal enactment what its citizens shall eat and drink, what kind of clothes they shall wear, how long they shall work, or even by whom they shall be attended when sick, etc., whereby the personal liberty of the individual is directly interfered with, without a compensatory benefit to his fellow-individuals as a whole, we must say that it is exceeding its prerogative. Strangely enough we often find many of those who are loudest in demanding a recognition of their own liberty of action the most tyrannical in restricting that of others. We need only recall the French Reign of Terror, and follow the accounts of the tyranny of the trades-unions in our own day. Do those who demand an eight-hour law for themselves give a thought to their wives whose work is never done, and upon whose well-being the well-being of future generations depends?

If eight hours should be the limit of work, and eight devoted to recreation and eight to sleep, let us ring the curfew bell as of old. Let us legislate good hearty meals into all the homes in the land, or rather let us first legislate into existence a home for each citizen.

We wonder at the blindness that prevents us from seeing whither

such legislation as that we refer to must lead. We seek to prevent adulteration of food by enactment and by inspectors. Quite right. But at the same time we forbid the manufacture and sale of the harmless and cheap oleomargarine, and compel the poor to eat rancid grease, called butter. Again, we try to prevent the sale of skimmed milk, although known to be quite as nutritious and far cheaper than whole milk. Is there no suspicion of class legislation in this? If the principle be once acknowledged that what is under certain circumstances objectionable should be declared under all circumstances illegal, and that what in certain conditions is desirable should be made universally so by law, the flood-gates are opened, and there need be no end to the petty tyrannies that cranks and indifferent log-rolling legislators may legalize. An Ohio physician wishes a law forbidding kissing, because of the well-known occasional dangers attending promiscuous osculation. A Kansas man wishes a law against the wearing of hoop-skirts by the women. Why there should be no law against high silk hats, on the plea that they are conducive to unæsthetic baldness, we cannot understand.

Although there is a law against the sale of cigarettes to any one under 16 years of age, one of our sapient lawmakers wishes a law against their manufacture and sale within the commonwealth. And so instances might be multiplied where the desirableness of an object under certain conditions has been the only excuse for seeking to legislate it into existence. We have laws enough; let them be enforced. Their multiplication tends only to weaken the self-respect of the individual and his regard for law. Laws standing on the statute books unenforced are the most powerful factors in the corruption of the public conscience. We see, therefore, nothing inconsistent in calling a law just and liberal in comparison with an illiberal and vicious one, and at the same time holding that the objects sought could have been better obtained by other means, and that, therefore, had it been expedient, we would have opposed its passage.

We physicians have been much to blame in the matter of hastily seeking legislation where a condition or circumstance has been thought "prejudicial to the public health." Instead of seeking by removing ignorance and carelessness to remove the danger, we have striven to avert it by an appeal to authority. A consideration of all the hardships and horrors that would attend a compulsory reporting of "consumption" among the contagious diseases, will convince us that the attempt now being made in that direction is one of those ill-advised measures to which we are referring.

Let us seek, as teachers of the people, to bring about what we consider desirable as a natural spontaneous outgrowth of increased knowledge and intelligence on their part, rather than by ordinances, which shall stand as monuments of our own far-seeing philanthropy.

SHOULD this journal, by chance, fall into the hands of any physician wishing to advertise without advertising himself, and to be kept before the profession and the public while keeping within the limits of The Code (we have heard that there are such extant), to him we commend the following gem from a late British journal. For elegance and beautiful simplicity it cannot be surpassed, and had its originator been an American, it would, no doubt, ere this, have been copyrighted. It is, however, still free to all, and, without hope of gain, we suggest that a column of Splints for Shattered Sensibilities, or Balm for Wounded Feelings, might be a valuable and attractive adjunct to some of the thousand and one periodicals that cater to the wants of the medical profession.

Here is the tidbit:

A DISCLAIMER.

Mr. — (we omit the name lest we be considered *particeps criminis*.—EDS. H. M.) writes to us that he is annoyed that some meddlesome person has inserted in a local paper his appointment as Senior Assistant-Surgeon at the Great Ormond Street Hospital for Sick Children. Meddlesome persons are a very "numerous host." We sympathize with Mr. —, and gladly insert his disclaimer.

THE TONGUE OF INFLUENZA.—Dr. Faisans finds it amongst the extremely varying symptoms to be the most constant. The tongue preserves its general form and does not become large and thick as in gastric disturbances, or dry and small as in typhoid fever. It is always moist and appears as if it had been wiped off with a compress. It is smooth, even and without furrows or prominent papillæ. But most characteristic is the bluish, porcelain like or opaline color which reminds one of the papules of the mucous membrane of the mouth and pharynx. This coloration may be found diffuse or in plaques; in the latter case the basis and middle of the tongue are uniformly "opaline" while the sides and tip are spotted or striped. This picture may be disturbed by complications. In gastric catarrh the tongue is large and soft, partially coated; in graver symptoms with, as for example, pneumonia, it easily becomes dry. This peculiar color is seen already in the second to third day of the disease, and may persist for several days after apparent recovery, an indication of threatening relapse. (De Shelley states that a pathognomic sign is the appearance of a vesicular eruption upon the velum palati and the mucous membrane of the pharynx and mouth. They are about from a half to one millimeter in diameter, and shine through like grains of sago. In 48 undoubted cases of the grippe he found this sign present in 47).—*Norsk Magazin for Lægevidenskaben*, No. 9, 1893.

GLEANINGS.

GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D., AND FRANK H. PRITCHARD, M.D.

HEART-SOUNDS AND ACCURACY IN CARDIAC AUSCULTATION.—In a lecture delivered at St. George's Hospital, Dr. Ewart discussed this subject and arrived at the following conclusions:

1. Each of the four heart-sounds can be separately heard at favorable spots, and these spots generally coincide with the sites of intensity for each of them. In other situations paired sounds may be heard simultaneously.

2. Loudness and accentuation belong to the first sounds over the ventricular area, and to the second sounds over the second inter-cartilaginous spaces.

3. The pulmonary sound (in the second left interspace) has a very limited extension, viz., hardly any towards the right, very little upward, and very little outward, but it extends a varying distance downward, generally blending with the aortic sound.

4. The aortic sound, culminating in the second right interspace, has a very wide area of extension, being loudly heard over the upper part of the sternum and over the cartilages and down to the third space, except over the small area of the pulmonary sounds. It is loudly conducted to the apex. It is very distinctly heard over the greater part of the right ventricle. It is heard above and for some distance to the right and to the left of the præcordium.

5. The ventricular area is divided by a vertical line, almost coinciding with the parasternal line, but not identical in situation in all subjects, into a tricuspid sound area and a mitral sound area. Thus a portion of the right ventricle serves to conduct the mitral sound.

6. The mitral sound is heard loudly to the left of the said line over the fifth, fourth, and part of the third spaces, but less loudly and mixed with the tricuspid sound over an intermediate area to the right of the vertical line.

7. A short horizontal line, extending from the curved extremity of the vertical line outward along the third interspace, marks off the upper boundary of loudness of the mitral sound. The first sound as heard at the right and left second spaces is probably chiefly mitral, but perhaps compounded of mitral and tricuspid elements.

8. The tricuspid is the only systolic sound heard over the lower half of the sternum and to the right thereof. It is also heard to the left of the sternum as far as the line of demarcation; but in the neighborhood of this line it is blended (in varying degree and over a zone varying in width in different individuals) with the mitral sound.

9. At the sternal end of the third left space, the systolic sound and the diastolic sound are both loud over a limited area, which may be termed the "auscultatory valve site." The loud systolic sound heard here is in the normal state, probably mitral, and the diastolic sound is probably aortic; but it is possible that the other two heart-sounds may participate in their production.—*Lancet*, 1893.

TREATMENT OF SUNSTROKE BY CHLOROFORMIZATION.—Dr. Koerfer, a military physician, treated two soldiers with grave sunstroke, loss of consciousness, clonic and tonic convulsions, considerable hyperæsthesia of the skin, cyanosis and weakness of the pulse, with success by prolonged inhalations of chloroform, the symptoms disappearing rapidly under this treatment. He was led to try this method by the good results which are attained by the use of this anæsthetic in eclampsia of pregnancy and the puerperium. Later he learned that a physician of the English East Indies had, in 1860, proposed to treat this condition by inhalations of chloroform. The favorable effect of the chloroform was manifest from the first inhalations by a sensible amelioration of the state of the pulse. But the complete

disappearance of the convulsions and the reflex super-excitability was only obtained by anæsthetization lasting in the first case one hour and fifteen minutes, and fifteen minutes in the second. In the first patient, who presented particularly grave symptoms, cold ablutions and subcutaneous injections of ether being without effect, inhalations of chloroform were tried, which only served to provoke convulsive seizures. An injection of morphine quited these, and the chloroform was administered; after recovering from the chloroform-narcosis he went to sleep again under the influence of the morphine. When he reawakened he was completely free from the symptoms of sunstroke. The favorable action of chloroform upon a pulse already enfeebled by sunstroke seems paradoxical. He explains it by stating that chloroform has a sedative influence upon the cardiac ganglions irritated by the overheated blood, suppressing, at the same time, the convulsions which help to elevate the temperature of the body, diminishes the production of heat, and thus facilitates the escape of caloric.—*La Semaine Médicale*, No. 45, 1893.

TWO RARE CARDIAC INSUFFICIENCIES.—Dr. Grawitz, of Berlin, describes two cases of rare insufficiency of the heart.

The first was a case of stenosis of the tricuspid in a baker of 24 years. Clinically there was great hypertrophy of the heart at the apex, and at the cartilage of the fifth rib of the right side, systolic and diastolic fremitus. Two loud murmurs were to be heard at all the valves, and especially loud over the apex and at the tricuspid valve. The diagnosis which was confirmed by autopsy was: stenosis and insufficiency of the tricuspid valve, of the mitral valve with slight endocarditis changes in the aortic valves.

In the second case, a woman of 45 years, with insufficiency and stenosis of the mitral valve disturbances of compensation arose, the ventricle enlarged, and there was added, to the already existing phenomena, a slight systolic and a long drawn out diastolic sound over the pulmonary valve, distinct diastolic fremitus at the right corner of the right ventricle which reached two fingers' breadth below the xiphoid process of the sternum. Hence a diagnosis of pulmonary insufficiency added to that of the mitral valve was made.—*Muenchener Medicinische Wochenschrift*, No. 37, 1893.

TREATMENT OF SYNCOPE.—Dr. Bobrof, in a study of prolonged syncope, classifies its treatment as follows:

Irrational and Harmful Measures.—Affusions of cold water, compresses of cold water, flagellation, frictions, tickling of the nasal fossae, inhalation of ammonia, ice in the rectum, irritant rectal injections, insufflation of air into the mouth or trachea, tracheotomy, subcutaneous injection of atropine, strychnine, ammonia, digitalis, ether, alcohol, inhalation of amyl nitrite, and introduction of needles into the substances of the heart.

Injections of ether (which are liable to cause paralysis from impingement upon a nerve.—EDS.), and the nitrite of amyl are absolutely injurious and are to be completely avoided.

Useful or Inoffensive Measures.—Inclination of the head of the patient downwards and backwards, transfusion of blood, subcutaneous injection of a solution of the salt, common salt, electrization of the phrenic nerve, artificial respiration, when respiration also is affected at the same time as the heart.—*Revista Medica de Sevilla*, Aug. 31st, 1893, vol. ii., No. 4.

ALTERATIONS OF THE URINARY STREAM.—Dr. Alexander Payer, of Zurich, has made a study of the changes in the urinary stream.

Projective Force of the Stream.—A strikingly strong stream is characteristic of a pathologically developed detrusor, due to hindrances to micturition in the urethral canal, such as follow moderate strictures, a narrow external orifice, or from spasm of the detrusor. A weakening of the projective force of the current is, at a certain age, pathognomic of prostatic hypertrophy, and is seen in weakening of the detrusor from chronic inflammation of the mucous membrane and muscular tissue, from neglected gonorrhœa, in atony from fatty degeneration of the muscular tissue, as in the course of acute infectious diseases, as typhoid fever or dysentery, and from voluntary retention of the urine where micturition is painful, as in stone in the bladder and fissures of the neck of the bladder. A decrease of force is observed in neurasthenics and in spinal diseases and tabes.

Decreased Calibre of the Stream.—Hypertrophy of the prostate, or stricture, will

diminish the calibre. In prostatics the current falls vertically down, and in stricture as well, but in the former the force is not increased by pressing, while in the latter it is. Spasmodic contractions of the urethra, from general diseases, may also cause a diminution of the calibre.

Altered Form of the Stream.—A deviation from the round form is observed as the earliest sign of stricture. In decreased force of expulsion the form is changed. Change of form is not a certain sign of stricture.

Continuity of the Stream.—Sudden stopping of the stream is supposed to be pathognomic of stone, but it is rarely observed except in children. If in adults, the stone must be very small and light. It is, relatively, frequently remarked in spasm of the sphincter in neurasthenics.

Starting the Stream, etc.—A drop-by-drop passage of the urine is characteristic of great stricture and great pressure. In some cases there follows a round and strong stream when it started drop by drop; spasm of sphincter.

Dripping of Urine.—Dripping of urine after passage of the stream is a frequent occurrence, and is of varying importance according as it appears after voluntary urination—a short time after or in the intervals. It is due to a relaxation of the muscular tissue of the urethra, and the urethra lying in a half opened condition does not press the urine out over the bulbous portion, so that it accumulates and is suddenly ejected after urination, or, it drips away slowly during walking. Narrow strictures also cause it, where the portion posterior to the stricture fills like a sack, and unless emptied by milking movements by the patient, it drains away afterwards. Abnormal narrowness of the orifice or very great phimosis are other causes. Involuntary urination may occur at any time while dripping only follows urination.—*Wiener Medizinischer Presse*, No. 33, 1893.

SYMMETRIC GANGRENE.—Dr. J. Borelius describes a case of symmetric gangrene of the lower extremities in a sailor of 33 years. It consists of symmetric affection, by gangrene, of the ends of the outermost terminations of the extremities i.e., of the fingers or toes, less frequently the ears or nose, or symmetric portions of the skin on the body. It appears under the form of a dry gangrene and it is supposed to be due to a vaso motor disturbance of the bloodvessels, and is independent of alterations in the circulatory system. It may extend up the extremity. It is to be differentiated from congelation, disease of the circulatory system, poisoning by *secale cornutum* and that of diabetes as well as leprosy. In congelation the season and previous history will determine, in affections of the bloodvessels the gangrene is not symmetric while changes are apt to accompany, in the heart and large vessels. The age is also advanced.—*Hygiea*, No. 7, 1893.

EARLY DIAGNOSIS OF PULMONARY TUBERCULOSIS.—Dr. G. Arthaud read a paper before the third session of the Congress for the study of tuberculosis, on the early diagnosis of tuberculosis pulmonum. The stage of tuberculous invasion, be it either primary or secondary, is a cyclic period of fifteen days when there are signs of gastric disturbance or as of typhoid fever, with a predominance of thoracic symptoms as dyspnoea, immobility of the thorax, abdominal respiration, very marked tachycardia, etc. These symptoms should exclude typhoid for the fever more resembles that of the doubtful stage of typhoid. A reliable physical sign is a general obscurity of the vesicular murmur which is almost pathognomic. Out of 200 cases this was absent but three times. Verification is always easy, for, after fifteen days rough bronchial breathing and later the râles appear. At this period one may prevent further complications and localize the deposits.—*Le Progrès Médical*, No. 31, 1893.

DURATION OF ISOLATION IN INFECTIOUS DISEASES.—Dr. Ollivier fixes the period of isolation from the first day of the invasion in scarlatina, small-pox, varioloid and diphtheria as forty days, in varicella and measles as sixteen days. In whooping cough the child should remain isolated for three weeks after cessation of the characteristic cough, and in mumps ten days after the swelling has disappeared. Before going to school, the nose, mouth and pharynx should be washed with antiseptic solutions, and the whole body and head be bathed. Baths with soap and water are recommendable. The room where the patient was sick should be carefully aired and disinfected, together with the cloths.—*Revista de Ciencias Medicas de Barcelona*, No. 16, 1893.

GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D.

TRANSPLANTATION OF LARGE SKIN-FLAPS WITHOUT A PEDICLE.—F. Krause (Altona) recommends the use of flaps without a pedicle, which include the cutis and cuticle only, to cover large skin defects. In many instances Thiersch grafts are not applicable, while pedunculated flaps are a source of great inconvenience or suffering at times, on account of the uncomfortable position necessary during healing.

The recommendation is based upon twenty-one cases, in which over one hundred flaps were used, only four of the latter necrosing. The size of the flaps makes no difference, if the field of operation is aseptic and the bleeding on the raw surface is completely checked. Such a surface must be a fresh wound, or be converted into one by removing granulations or excising fibrous tissue. The grafts take equally well on muscle, fascia, connective tissue, dura mater, periosteum, or denuded, cancellous or compact bone. If an excavation exists, it becomes lifted to the level of the skin, as after the application of Thiersch grafts.

The raw surface is disinfected with bichloride, which is washed off with salt solution, and then dried with sterile gauze. The Esmarch bandage is used, and the tourniquet removed at the close of the operation.

The skin from the inside and front of the arms and front of the thighs, or from the buttocks, is usually taken; but as skin from any part can be transplanted, defects in hairy portions can be corrected with hair-producing skin. This surface is prepared by disinfection and salt solution like the raw surface, but vigorous scrubbing is to be avoided. It is also to be thoroughly dried, and the hands, instruments, etc., must be dry. The whole flap is marked out with the knife, when its lower angle is lifted, and it is dissected off. The delicate connective-tissue layer between the skin and the subcutaneous fat, comes away with the flap. If any of the fat is removed with the flap, it can be trimmed off afterward, and if a little remains here and there it will do no harm. An oval or spindle-shaped piece of skin should be removed, so that the resulting defect can be closed by immediate suture; if necessary, the flap may extend the whole length of the limb, and yet be of such a width as to allow the defect to be closed. After removal it is folded, the raw surfaces against each other, and held between the fingers until applied to the wound, when it will be found to have contracted about one-third. A little pressure causes it to adhere. The entire raw surface should be covered. Sutures are not necessary, and no ligature should be applied to bleeding vessels, for they act as foreign bodies, and prevent adhesion.

The dressing consists of sterile five per cent. iodoform gauze, held in place with moderate firmness, and a splint. At the end of three or four days the dressings should be changed, as vesicles are apt to form. The outer layers of gauze are removed, while the inner are soaked off by immersing the limb for an hour or more in boracic solution. Iodoform gauze, covered with boro-vaseline, can then be used. At the first dressing the flaps are swollen and look pale, or livid from infiltration of blood pigment. In a week they become rosy, and this is more pronounced when the epidermis comes off. There may be necrotic spots, involving the whole thickness, but the greater part of the flap retains its vitality. When this process is superficial, the deeper glandular tissues remain alive, and quickly form new skin.

Healing requires from three to six weeks, the variation being due to differences in vitality of the raw surface and of the patient. Sensibility appears late. The new skin becomes movable, and subcutaneous fat is formed beneath it.—*Verhandlung der Deutschen Gesellschaft für Chirurgie; Centralblatt für Chirurgie.*

TRANSPLANTATION (WITHOUT A PEDICLE) OF FLAPS, INCLUDING THE SKIN AND SUBCUTANEOUS FAT.—M. Hirschberg (Frankfort) reports four cases in which defects after the extirpation of tumors were successfully filled with such flaps. The defects were made in quadrilateral form as much as possible, with steep borders. While the bleeding was being controlled by pressure and an occasional ligature of very fine catgut, the grafts were taken from the forearm as follows:

The extremity was rendered bloodless with the Esmarch bandage, and the constrictor applied to the middle of the arm. The outer side of the forearm was

whipped with a piece of rubber for several minutes. A flap, one-third larger than the defect, to allow for shrinkage, was cut out, down to the deep fascia, on three sides, leaving the fourth attached. Needles, threaded with silk, were passed from skin to raw surface at short intervals along the edges, and left hanging in place. The constrictor was removed from the arm, when the flap became red and swollen. The author's idea is to make use of a tissue rich with bloodvessels, paralyze these by beating the part so that they may hold as much nutritive material as possible, which shall keep the cells alive until the flap becomes joined to its new bed. When deeply congested the flap was removed by cutting through the attached side, any superfluous lobules of fat trimmed off, and it was laid in the defect. The needles were passed through the edges of the latter, from within outward, the union being made more accurate by a few additional sutures of fine silk. The fourth side was then similarly sutured after the blood had been squeezed out from underneath the flap—a small gap being left to give vent to any subsequent oozing. The dressing consisted of a protective, gauze and cotton, held in place with a moderately firm bandage.

The flaps presented a perfectly normal, rosy appearance for five or six days, although they looked quite pale for the first few hours. Between the fifth and seventh days the flap became blue either over the whole or the greater part of its surface, or at its borders. This portion separated from the fourteenth to the eighteenth day, as a superficial slough with a scanty discharge, showing the red, slightly swollen cutis underneath, which soon became covered with cuticle.

In the ensuing discussion, Nenber (Kiel) reported a case of deep, funnel-shaped scar following the healing of a bone operation. The scar was incised and loosened, and the cavity filled with a bit of fatty tissue taken from the patient's arm. The wound was then sutured. The result was excellent. The smaller the piece of fat the more likely it is to heal in.—*Verhandlungen der Deutschen Gesellschaft für Chirurgie; Centralblatt für Chirurgie.*

DIRECT FIXATION OF THE FRAGMENTS IN COMPOUND AND UNUNITED FRACTURES—N. Senn (Chicago) thinks that the methods at our command for accurately fixing the fragments in compound and ununited fractures are crude and inaccurate, and that in such cases, or even in certain simple fractures with much tendency to displacement, the attempt should be made to approximate the divided bone with as much accuracy and stability as is done with the soft parts.

After reviewing the recently proposed methods of uniting the fragments by bone suture, bone ligature, metallic spikes or screws, ivory pegs, ivory cylinders and clamps, he suggests, in place of the ivory, intra medullary cylinders, similar ones of perforated bone. These are made of the shafts of the bones of young animals, such as chickens, turkeys, or rabbits. The medullary cavity can be increased in size by the use of a small round file, and the perforations made with a drill. They are boiled for an hour and kept in sublimate alcohol. The length of these intraosseous splints will vary according to the size of the bone and the obliquity of the fracture from one to three inches. Displacement of the splint upward or downward need not be feared if additional immobilization is secured by an appropriate external support.

As a result of experiment and clinical experience, the author further recommends the use of bone ferrules for the direct fixation of the fractured ends. Over-riding is thus obviated, while angular deformity is prevented by external support.

These ferrules are made of different sizes from fresh bone obtained from the slaughter-house or butcher-shop. For the humerus or femur of an adult, the femur of an ox should be selected; for children, the same bone in a smaller animal. For the tibia, the corresponding bone of the animal is taken. The shaft is cut transversely into sections of varying width, from a quarter of an inch to an inch. The medullary canal is enlarged with a round file, until the bone is not more than one-sixth of an inch thick. Even a thinner ferrule will often answer, and, if it is more than an inch wide, it should be perforated at a number of points to facilitate tissue proliferation and absorption. Partial decalcification may be advisable, or it may be well to make them of chromicized catgut.

Three cases have been treated by this method:

1. An ununited fracture of the femur was cut down upon, the broken ends freshened, freed, and held together with a bone ferrule. This was cracked during its application, after two others had been broken, and was strengthened by being wrapped with chromicized catgut. The shortening was only reduced one inch, as

the over-riding could not be overcome and the ends had to be sawn off. The wound suppurated and the unabsorbed ferrule was removed. Good union was expected.

2. An ununited fracture of the humerus, with considerable bony defect, was united by impacting the fragments and holding them in place by a bone ferrule and catgut stitches. The partially absorbed ferrule was removed at the end of seven weeks through a fistulous opening which formed after the soft parts had healed. The fragments were firmly united by an abundance of callus.

3. A compound, comminuted fracture of the leg, with sloughing and suppuration, was treated by fixation of the fibular fragments with a bone ferrule. This could be seen to hold them firmly together for four weeks, until consolidation was sufficient to warrant its removal.—*Annals of Surgery*.

PROSTATIC HYPERTROPHY TREATED BY CASTRATION—F. Rocum (Christiania) has been led (1) by the unsatisfactory results following the many methods used to relieve this condition, (2) by the fact that, after all, the palliative catheter is the only universally accepted treatment, and (3) by the analogy between the uterus and prostate, to see whether the results of oöphorectomy on uterine myomata could not find a parallel in the effects of castration on hypertrophies of the prostate.

Experiments on dogs showed that in one to two months double castration was followed by diminution in the size of the prostate; the same was found to be true in swine.

Double castration was tried on a man of 73 years, who was suffering from retention of urine. The prostate projected into the bowel, and was as large as an ordinary apple. Urinary difficulty had been present for fifteen years; the catheter had never been resorted to. The catheter was used to relieve the urgent retention, and only three or four times during his stay of two months in the hospital. Two weeks after the operation the patient was presented to the local medical society. The prostate was much smaller, and the wounds were healed. This atrophy continued until he was able to resume his work, and urinated three or four times during the day and twice during the night. Nothing is said of the residual urine.

Another case had used the catheter for a long time and suffered from cystitis. The results were about the same.—*Centralblatt für Chirurgie*.

(At last there seems to be a prospect that the much-abused ovary may see its day of revenge!—Eds.)

SUPRAPUBIC CYSTOTOMY IN TWO TEMPOR.—Senn (Chicago) proposes, in cases of septic cystitis, to perform this operation in two stages. For the first stage the patient is anesthetized, and the rectum and bladder distended in the usual manner. The field of operation is rendered aseptic, and the bladder is freely exposed by dissecting away the prævesical fat over an oval surface about two inches in length and half as wide. After arresting the hæmorrhage, the wound is firmly packed with iodoform gauze and the external dressing fastened by strips of adhesive plaster, which are made to encircle the pelvis, and which prevent the dressing from becoming displaced. At the end of five days, the dressing and iodoform gauze are removed and the bladder is distended and incised, without the use of an anæsthetic if it is intended simply to establish a supra-pubic fistula, or if a small stone is to be removed. More serious intravesical operations would require the use of an anæsthetic. If the wound has remained aseptic, it will now be found covered throughout by a layer of active granulations. These granulations have closed the connective-tissue channels, and have shut out from the wound the balance of the prævesical space. When no anæsthetic is used, the wound-surfaces are brushed over with a 5 per cent. solution of cocaine. The bladder is incised and drained in the usual manner, and, as the septic urine is harmless to the granulations, the dangers of the operation are lessened.

From a study of his cases, Senn formulates the following conclusions:

1. Necrosis and phlegmonous inflammation of the margins of the wound and the tissues in the prævesical space not infrequently occur as complications of supra-pubic cystotomy, if the operation is performed for affections complicated by septic cystitis.

2. Supra-cystotomy in two stages greatly diminishes, if it does not entirely overcome, this source of danger.

3. In the first operation the bladder is freely exposed in the usual manner, when the prævesical fat is dissected away over a vertical oval space at a point corresponding to the location of the proposed visceral incision, after which the wound is

packed with iodoform gauze, and the external dressing is applied in such a manner that it cannot become displaced.

4. The incision in the bladder and the intravesical operation are postponed until the external wound has become covered with a layer of active granulations, which usually requires from four to six days.

5. The second operation can be performed with the aid of cocaine, without general anæsthesia.

6. This modification of supra-pubic cystotomy diminishes the immediate risks of the operation, and affords protection against a number of serious post-operative complications.—*Medical News*.

GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D. AND J. NICHOLAS MITCHELL, M.D.

THE DIAGNOSIS OF PELVIC ADHESIONS.—First, the history of the case; second, the normal anatomy that should exist in a woman's pelvis if she is healthy; third, the deviation from the normal anatomy which has taken place; fourth, the number of adhesions which exist, the ease with which the uterus can be replaced, or the persistency with which it returns to its old position and stays there. Then add to that the knowledge to be gained from digital touch, and the fact that you know, from your understanding of the normal anatomy of the pelvis, that you have a uterus bound in such a position that it is inelastic to the touch; that in place of having the fundus point toward a spot midway between the umbilicus and the symphysis, you find it in an abnormal position.—*New York Journal of Gynecology and Obstetrics*.

RELATIONS OF GENITAL DISEASE TO MENTAL AND NERVOUS AFFECTIONS.—Landon Carter Gray, M.D., draws the following conclusions in regard to these:

1st. That there is no proof that genital irritation in the male or female can cause nervous or mental disease except in a predisposed individual.

2d. That the proof is not yet absolute that genital irritation can produce nervous mental disease, even in a predisposed individual.

3d. That there is undoubted proof that the relief of genital disease in the male or female will often relieve certain nervous diseases, such as migraine, hysteria, epilepsy, simple nervousness, and hallucinatory insanity.

ECTOPIC GESTATION—DIAGNOSIS.—A. W. Edis, London, says of ectopic gestation that there may or may not be the symptoms of normal pregnancy. The evidence on this point varies greatly. In some it is overlooked, and no suspicion of pregnancy arises. In other cases the mammary and minor symptoms of pregnancy are well marked. The patient's attention is first directed to irregular gushes of blood from the vagina, ceasing and suddenly recurring without assignable cause; more or less fixed, grinding pain in one or the other iliac fossa, which occasionally extends down the inner aspect of the thigh. Severe paroxysmal pains in the same locality, with constitutional symptoms, soon passing off to return again in a few days with increased violence; symptoms of abortion without any appearance of foetus, merely the expulsion of shreds of membrane, clots or rarely a complete cast of the uterus in the form of a decidual membrane, leading the patient, as well as the practitioner, to believe that a miscarriage has taken place. The patient may give a history of several years of unfruitful married life or infertility following a severe miscarriage or confinement. Then a period is missed or the interval unduly prolonged. The usual symptoms of pregnancy may be illy defined or absent, though the patient frequently has the conviction that pregnancy exists.

In vaginal examination the uterus is generally found to be bulky and pushed to either side of the pelvis by some more or less defined tumor or swelling, which is often tender on pressure. There may be occasional discharges from the vagina, with possibly shreds or clots, and the occurrence of paroxysms of pain limited to one or other inguinal region. After, possibly, a number of attacks of colicky pain,

with intervals of entire freedom, the patient, in the third or fourth week, is suddenly seized with pain in the lower abdomen, as if some irritating poison had been taken or something inside had been torn away. Fainting, collapse, clammy perspiration, occasionally convulsions and delirium ensue, with symptoms of violent shock and internal hæmorrhage, from which she may die in a few hours.—*Universal Medical Journal*, August, 1893.

FATTY DEGENERATION OF THE MUSCLE-CELLS OF THE UTERUS DURING THE PUERPERIUM.—Helene, of Edinburgh, disputes this. The clear hyaline appearance of the muscle-cells becomes cloudy during the first thirty-six hours; there is at the same time a rapid diminution in volume at first, and then it is more gradual; but the muscle-fibres never die, as some authors assert. The connective tissue degenerates in part. He believes that the leucocytes, which are found at the close of pregnancy, take up the products of degeneration of the connective tissue.—*Transac. Royal Soc. Edinburgh*, vol. xxxv., Part II., No. 8.

A NEW OPERATION FOR POSTERIOR DISPLACEMENT OF THE UTERUS.—It consists in sewing the fundus uteri to the anterior wall of the vagina. The operation was designed by Mackewrodt, and Winter has modified it as follows: The cervix is drawn down to the vulva. Anterior kolporrhaphia is then performed with oval freshening two fingers wide, in uncomplicated retroflexion somewhat broader. The anterior lip of the cervix is freshened in a line with that on the vaginal wall, and the bladder is dissected up from the uterus to the vesico-uterine excavation, i.e., up to the peritonæum. The hæmorrhage is often free, from some branch of the uterine artery. The bladder is held up with a speculum. The uterus is then fixed with two silk-worm sutures. The needle is inserted on the inner or freshened surface of the anterior vaginal wall, then through the vesico-uterine excavation through the uterus, 1-1½ c.m. broad, and then out on the inner surface of vaginal wall opposite to its insertion. Some bleeding may follow the insertion of these stitches, which bring the uterus forward when they are tightly tied. The stitches must be cut very short or the ends will prick through the vaginal wall and disturb union. The rest of the wound is treated with continuous catgut suture in the usual manner, the cervix and a part of the anterior vaginal wall being sewed together to avoid a pocket for collection of blood and exudate in the anterior fornix of the vagina.—*Centralblatt für Gynäkologie*, No. 27, 1893.

EFFECT OF MORPHINE ON THE SEXUAL SPHERE.—Passower has observed that the chronic abuse of morphine leads to atrophy of the genitals. Two of his patients were aged 29 and 30. They came to be treated for amenorrhœa and the periods returned during treatment for morphinism. The periods ceased again with the taking of morphine and the depth of the uterus diminished in two years and a half from 8 c.m. to 5 c.m. Analogous changes are observed in the submaxillary glands of dogs dosed with morphine (Experiments of A. Bernard), and also in the ovaries of morphine takers. The atrophic process probably begins with the ovaries, extends to the uterus and the external genitals.—*Centralblatt für Gynäkologie*, No. 2, 1893.

CANCER OF THE UTERUS.—Early Diagnosis.—The classical symptoms of cancer of the uterus are hæmorrhage, offensive discharge and pain. When these are all present the disease has usually spread beyond the uterus.

A sign of great value in early diagnosis of cancer of the cervix is hæmorrhage following sexual intercourse. Whenever this occurs the case should be thoroughly investigated.

When women have ceased to menstruate, and again have a metrostaxis, the case should be carefully studied.

Leucorrhœa is common in the early stage of cancer.

Pain is present in almost all cancers late in their course. *It is seldom an early symptom.*

Epithelioma may or may not be difficult of diagnosis at an early stage. When a definite area in the cervix is hard, infiltrated and constitutes a distinct mass or tumor in the cervix, it is probably cancer and should be examined microscopically. When the mass begins to ulcerate the diagnosis is plain. Cancer of the body of the uterus is almost always the malignant adenoma.—*American Gynecological Journal*.

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY
CHAS. M. THOMAS, M.D.

TREATMENT OF PSEUDO MEMBRANOUS LARYNGITIS BY THE SUBLIMATION OF CALOMEL.—The treatment of pseudo-membranous laryngitis by the sublimation of calomel, while calling for care and thoroughness, does not, like tracheotomy or intubation, require special skill in the operator, and it has the advantage of being available for immediate and repeated application by those in attendance in the absence of the physician. Its use should be begun early, as soon as a diagnosis of true croup can be made, or before, if there is a strong suspicion of a membrane forming in the larynx, as evidenced by a peculiar, dry, barking cough, the disturbance and difficulty of respiration, etc.

The patient should be placed in a large, well ventilated apartment, in which a temperature of about 80° F. can be maintained, and the air of the room kept well moistened by steam obtained by boiling water, or slacking lime, or, still better, the following: *Acidi carbolic*, ol. *eucalypti*, â 1 ounce, *spts. terebinth.*, 8 ounces. "Add two tablespoonfuls to one quart of water, in a tin or zinc wash basin, or pan of broad surface, and maintain a constant state of ebullition or simmering in the room occupied by the patient."

The apparatus consists of a tent and an alcohol lamp. For a tent the child's crib or a cot, may be used. The uprights at the ends may be formed of bed slats, broom-handles, etc., with a broom-handle, slat, or stout cord to form a ridge pole. The covering of the tent may be made of sheets or blankets. To keep the air in the tent as pure as possible it is desirable to consume but little time in the burning of each powder. This also avoids raising the temperature in the tent to too high a point, and charging the air with an unnecessary amount of carbonic acid gas. The tin cover of a blacking box, or piece of sheet-iron (the thinner the better, to favor rapid sublimation) should be placed upon the tripod of the lamp.

The quantity of calomel used in each sublimation should be from thirty to sixty grains; the sublimation to be completed in as short a time as possible. The intervals of treatment vary. When the breathing is especially labored and difficult, the burning of the calomel may be required, for a short period, half-hourly; but usually the treatment is repeated every two or three hours, increasing the interval as the period of relief extends. In some cases the whole quantity of calomel used has been from one-half to several ounces. In one case that recovered eight ounces were used. When possible, oxygen should be available for immediate administration; it will often be of service, and may occasionally save a life. Special attention should be given to sustaining the strength of the patient by nourishment and stimulants, particularly following each sublimation.

Dr. Law states that while mercurial fumigation will not take the place of surgical means, no physician is justified in performing intubation or tracheotomy in pseudo-membranous laryngitis until fumigation has been tried, nor, that failing, is he justified in allowing a patient to die without surgical attention. After intubation or tracheotomy, when there is evidence, or reason to suspect the formation of a false membrane below the tube, the sublimation of calomel should be employed or continued.

Of 505 cases of true croup treated by the sublimation method, 275, or about 54.5 per cent. recovered. Eighty-five of the 505 were tracheotomized or intubated after having been unsuccessful treated by the sublimation method. Of these, 29 recovered. Therefore, 48.7 per cent. of recoveries took place from the sublimation alone. It is worthy of note that in these statistics the percentages of recoveries in those cases first treated by the sublimation method and then either intubated or tracheotomized is greater (34.1 per cent.) than those treated by either tracheotomy (24.2 per cent.) or intubation (30.5 per cent.) without the sublimation treatment.

Dr. J. O'Dwyer states that during the two years that he has been using calomel fumigations in the treatment of croup, he has saved at least twenty cases from intubation. He thinks it the most valuable therapeutic measure in the treatment of croup, at present within reach.—Brochure by William Maddren, M.D.

QUACK OCTLISTS.—*The British Medical Journal* thinks that the *Standard* has done well to call public attention to the cruel frauds perpetrated by unscrupulous

quacks on their credulous dupes, and states that the country is overrun at the present time by persons, of various and often doubtful nationality, who call themselves oculists, and grossly abuse the ignorance of the public. One of the instances quoted in the *Standard* was that of an old woman, an inmate of an almshouse, who was induced to give a guinea for a pair of "electric spectacles" to improve her sight, and at the same time to cure her rheumatism. In another instance a patient suffering from cataract was persuaded that "the skin" had been removed from her eye, and even signed a testimonial to that effect, but when she sought skilled advice the cataract remained. In other cases the quack does some operation—a crude form of couching, and many eyes are lost. The London and Counties Medical Protection Society are taking legal action against one of these so-called Indian oculists, and a warrant has been issued.

DISEASE OF THE HORIZONTAL SEMICIRCULAR CANAL.—Richard Lake, F.R.C.S., Eng., etc., reports the case of a young man who had suffered with left otitis media purulenta, complicated by inflammation over the apex of the mastoid and a polypus lying deep in the meatus, which, after removal, was found to have sprung from the entrance into the mastoid antrum. Upon touching this polypus with a probe severe vertigo was produced, which was described by the patient as being "side to side" in character. The polypus was removed, when he almost fell to the opposite side. Nystagmus was not noticed. Pressure on the stapes did not reproduce the vertigo, but firm pressure in the region of the horizontal semicircular canal, above and behind the fenestra ovalis, caused the vertigo and the tendency to fall.

Lake also reports another case, that of a lad who had suffered from left otitis media purulenta for eleven years. In this instance the mastoid antrum was opened, and to syringe through this canal, formed by the bone sinus, attic and external auditory meatus, which latter was extremely narrow and contracted, considerable force was used, and the pressure of the fluid in the middle ear raised above what could have been obtained had no contraction of the meatus been present. Suddenly during the syringing the boy complained of vertigo, "side to side" in character, and when his eyes were fixed, a lateral nystagmus was developed.

On section of the horizontal canal in mammals there occurs a rapid or "side to side" pendulous movement of the head, with lateral nystagmus; and if this—the result of experimental research—is compared with the clinical facts related in the first case there will be found a spot in the position where the horizontal canal reaches the surface, which on pressure gives rise to the vertigo. In the second case, although the exact spot is not localized, lateral vertigo and lateral nystagmus are to be produced by abnormal pressure in an ear for a long period eroded by the action of pus. These symptoms are exactly similar to those caused by experimental injury to the horizontal semicircular canal.—*The Lancet*, Aug. 19, 1893.

RAPID TREATMENT OF DACRYO-CYSTITIS.—Denti (*Gazz. degli Ospitali*, July 25, 1893), in the treatment of cases of dacryo-cystitis, which has been in existence for months or years, and which has become complicated by caries of the bones and distortion of the lachrymal sac, does not think the usual method of opening the duct and dilating by means of probes sufficiently energetic. He proceeds as follows: An incision is made into the anterior wall of the lachrymal sac, including the palpebral ligament and the summit of the sac. The stricture is then divided and the sac scraped. The bleeding is stopped by antiseptic tampons, after which the incision is closed by suture. If the dacryo-cystitis is acute, and if the surrounding parts are much inflamed, the author delays the introduction of sutures for two or three days; if there is much ectasis of the sac he excises as much as may be necessary to remedy this state of things. This treatment has been highly satisfactory in his hands; the pain is reduced to a minimum, and quickly passes away; the reaction, whether local or general, is practically nil; the cure is rapid and certain.

EYE SYMPTOMS IN CEREBRO-SPINAL MENINGITIS.—Randolph, of Baltimore, first draws attention to the number of eye affections which may occur in this disease. Among them are conjunctivitis, altered pupils, pus in the anterior chamber, inflammation of the choroid and iris, suppurative cyclitis, panophthalmitis, retinitis, neuritis, etc. The fundus should always be examined, as there is a direct communication between the arachnoid space and the deeper structures of the eye through the intravaginal space. Every extensive epidemic is apt to be associated with a special type of eye diseases, as tortuosity and distension of the retinal veins with congestion of the disc. The author looks upon eye lesions, and especially fundus changes, as signifying grave cases.—*Bulletin Johns Hopkins Hospital*.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D., AND FRANK H. PRITCHARD, M.D.

AN ALLOPATHIC PROVING OF DIGITALIS.—Mrs. S.; age, 50; weight, 250 pounds; the wife of a German farmer; had been under allopathic treatment for over two months for heart disease. The diagnosis had ranged all the way from “angina pectoris” to “aneurismal disease of the arch of the aorta,” but had finally settled into “fatty degeneration.” She had taken brandy as a stimulant, and as much of the fluid extract of digitalis as she could bear. When she came under homœopathic treatment her condition was as follows: body and limbs cool and bathed in perspiration; heart’s action very feeble, 48 per minute; great dyspnœa; almost complete amaurosis; intense and persistent bilious vomiting, which did not seem to be aggravated by food, though she ate but little; also a passive metrorrhagia which had lasted for several weeks; peritoneal cavity was filled with ascitic fluid and the hearing was greatly impaired.

Nuxvom. was prescribed and the patient ordered to take a small portion of brandy, and, as a diet, koumiss. The next day the vomiting was found to be less severe, and *nux* and *cactus* were given. At the end of a week all symptoms were greatly improved, and in about two months she was discharged cured, in spite of the fact that an unfavorable prognosis had been given by the old-school physicians who had seen the case, and “doubtful” by their successor.

There is little doubt that a great majority of the symptoms were produced directly from the poisonous action of digitalis. This drug has in its pathogenesis the terrible vomiting, the paralysis of the retina from anæmia of its vessels, the cold sweat, depressed pulse and feeble action of the heart, the dyspnœa and the uterine hæmorrhage from engorgement of its venous capillaries, the effusion of fluids from all serous surfaces.—*Medical Arena*, September, 1893.

NATRUM PHOSPHORICUM.—This drug was proved by Dr. E. A. Farrington, who alludes to it but once in his *Clinical Materia Medica*, and that for a prominent symptom produced in his provers, namely, “Seminal emissions, at first with lascivious dreams, but later without any sensation whatever, which were followed by weakness of the back and by trembling of the limbs, which felt as though they would give way.”

Schüssler recommends the remedy in the so-called acid diathesis, for troubles arising from an excess of lactic acid in the system. The characteristic indications which he gives, in general, consist of a moist, yellow-coated tongue, acid eructations and vomiting of some cheesy masses; sour, greenish diarrhœa. It is very useful in acid dyspepsia and acid diarrhœas in children.

Another condition for which Schüssler recommends *natrum phos.* is scrofulosis; it seems to have a specific action on glands, enlarging them; in fact, it was used as a remedy for goitre long before tissue-remedy time.

In all former editions Schüssler recommends *kali mur.* as the chief remedy for gonorrhœa, but in the last edition he claims to have found a better one in *natrum phos.*, which he also finds becomes the chief remedy in catarrh of the bladder.—*Ibid.*

COCAINE POISONING.—The time of the appearance of symptoms varies, sometimes being delayed for hours, but in nearly every case they occur within two or three minutes. At times the effects of the drug are seen immediately.

The symptoms of cocaine poisoning of most value from a diagnostic point of view

are: sudden faintness and vertigo; feeble, frequent, irregular or intermittent pulse; shallow, irregular or convulsive respirations, and sense of suffocation and numbness. Other symptoms sometimes noted are: headache, pallor, loss of taste and smell, impairment of speech and deglutition, dryness of mouth and throat, dilated pupils, nausea, vomiting and gastric cramps, perspiration, restlessness, paralysis, convulsions, delirium and death.

As regards treatment, no antidote compares with nitrite of amyl. The inhalation of a few drops gives strength to the failing heart, color to the pale face, and causes full inspirations. Aromatic spirits of ammonia is another good antidote. Digitalis, glonoine, brandy, coffee and faradization have been useful in bringing about a reaction.—*Ibid.*

VINCA MINOR.—This remedy belongs to the vegetable kingdom, and is prepared from a tiny herb which blossoms as a little blue flower. It was much prized by the older physicians in lung and throat troubles. Proving of the plant establish the following symptoms: Sore throat, with coughing, hoarseness; ulceration in the nose, with stopping up of that organ and ulcerous flakes in the mucus. In spite of the established results from the use of this plant, it does not seem to be very popular or well known to homœopathy. Dr. Heinigke recommends it for plica polonica, inflammatory affections of the mouth, pituitous tunics, diarrhoeic stools, and bleeding from the nose and womb. That the vinca minor can become a power in the handling of diphtheria as well seems indicated in the provings of the drug upon the sound, and by its efficacy in sixty cases of the disease, in each of which recovery followed the administration of the plant.—From *Paris Letter to Medical Century*.

FERRUM METALLICUM.—This remedy has a decided action upon young persons who are subject to irregular distributions of blood. When the patient is unexcited and quiet, the face has a pale, earthy hue; but under the slightest excitement or emotion the face becomes flushed and the cheeks bright red. The irregular distribution of blood causes congestion to the head; hammering pains, worse after 12 P.M., returning periodically; throbbing pains in the top of the head when moving suddenly; hot head; cold feet. With all symptoms there is flushed face and aggravation after midnight. All symptoms are relieved by walking slowly; this is a characteristic symptom of the drug. In chlorosis, ferrum met. corrects the want of power on the part of the system to assimilate the iron in the food, and is indicated by the pale face, flushing easily, etc.

The stomach is always disordered; subject to frequent attacks of gastralgia and heavy pressure in the pit of the stomach. There is palpitating in the stomach and œsophagus with an occasional suffocating feeling. The mucous membranes are abnormally pale, showing their bloodlessness. The appetite is good and bad alternately, with aversion to meat and an appetite for bread. In diarrhoea, the stools are of undigested food, occurring as soon as he eats anything, or they may be painless and involuntary during a meal; these symptoms recur periodically after midnight.

The pulse is full and yielding, from the power of ferrum to dilate the bloodvessels, thus distinguishing it from aconite.

The menses are watery or lumpy in character, preceded by labor-like pains; they come on with physical languor and mental depression unfitting her for work; could overcome them by forced exertion; she is relieved by exercise.—*Southern Journal of Homœopathy*, September, 1893.

THE NUX VOMICA PATIENT.—This particular type of patient is of active, vigorous, and irascible temperament; or one of a cautious, phlegmatic disposition. They are generally thin, wiry, and dark complexioned. Nux is more especially suited to the male, than to the female sex. The nux patient complains of pain in the stomach after food. Not only this pain, but all the symptoms are aggravated by eating. The pain does not usually begin until half an hour, to one or two hours after eating, and varies in character from a mild form of heaviness or weight in the epigastrium, to the sensation of a heavy weight or dead pressure, or to a pain of a pressive, cramping character. The stomach invariably feels distended from flatulence, and to relieve this the patient unbuttons his clothes. A sense of nausea is frequently felt after eating, going on, it may be, to actual vomiting. Flatulent eructations are a constant symptom, which may even have a foul taste, and eructations of sour fluid are common, giving rise to heartburn. There is bad taste in the mouth, especially in the mornings, the breath is offensive, and often certain articles of food

taste bitter. The tongue is characteristic—it is clean, or fairly so, in the front half, but at the back it is covered with a thick, yellowish-white, slimy coat. Headache is almost constant, worse in the morning, and after meals; it is felt in the forehead, from temple to temple, and often in the back of the head. The sensation is one of fulness, a hot, congested, heavy aching, or throbbing, and the eyes feel heavy and full. There is aversion for mental exertion. Constipation is invariably present, not with an absence of desire for stool, but with a sense of uneasiness from want of relief, and inability to get a movement, or perhaps has a small unsatisfactory one, and soon has to go again. The *nux* patient presents a characteristic sleeplessness. He goes to sleep in the early part of the night, perhaps heavily, wakes at 2 or 3 A.M., lies wide awake for a long time, while thoughts crowd into his mind and prevent his getting off to sleep again. Towards waking time, he falls into a heavy sleep, and on being roused feels unrefreshed. The *nux* patient leads a sedentary life, eats too much, and drinks too much of alcoholic stimulants; and in fact, when one finds that such are the habits of life, it is an additional reason for the selection of *nux*.—*Monthly Homœopathic Review*, September, 1893.

THE ACTION OF PULSATILLA ON MUCOUS MEMBRANES.—Besides its action on the ovario-uterine sphere, the great action of *pulsatilla* is on the mucous membranes. It causes there a catarrhal irritation of a subacute and chronic type, associated with free secretion of mucus. Thus, beginning at the head, the *pulsatilla* case shows tendency to blepharitis, with free meibomian secretion, conjunctival redness, with free secretion; in the nose, the type of catarrh is that after the acute stage is over and when there is very free secretion of mucus or muco-pus, not thick, but requiring constant blowing of the nose. In the respiratory tract, the cough is attended by the same free expectoration which comes away easily and profusely. The same type of catarrh appears in the uterus and vagina. The cervix secretes mucus or muco-pus freely, a certain amount of redness being visible at the os, and from the vagina there is a free flow of leucorrhœa, generally of a bland type, and of a whitish-yellow appearance. There may be some catarrh of the bladder, causing frequent desire to urinate, with some uneasiness in passing urine; on examining the urine, a marked quantity of mucus is found. A similar condition of catarrhal irritation is found in the stomach and associated organs.—*Ibid*.

DIGESTIVE SYMPTOMS OF PULSATILLA.—There is little appetite, but sometimes there is a craving for food, which vanishes when food is placed before her. After partaking of food, there is a sense of general uneasiness in the stomach, with feeling of distension, and a desire or necessity for loosening the clothes. Then follow, acid or sour risings, the gulping up of a taste of the food swallowed, and a sense of nausea which may be followed by vomiting, the vomited matter containing much mucus. These digestive symptoms are especially caused by eating rich or fatty food, or by such indigestible food as pork. The mucous membrane of the stomach is evidently in a state of catarrhal irritation, with much mucus secreted; the food ferments and decomposes, forming lactic and butyric acids. The tongue is very characteristic; it is white, not covered all over with a uniform smooth creamy coat which is characteristic of *antimony*, but it is thickly coated with a rough white fur, or in some cases the rough fur coats only the posterior half. There is marked dryness of the mouth but with no thirst or desire for drink—only a desire to moisten the mouth. With the dryness there is a bad taste, rarely bitter, but a sour, foul, and sometimes salt taste. The *pulsatilla* patient is worse in the evening, contrasting with the *nux vomica* patient who is worse in the morning. The bowels are usually inclined to be loose not always amounting to diarrhœa; the stool is soft and markedly mucous, the action taking place in the evening, usually, while if diarrhœa is present, it is in the evening or at night. The *pulsatilla* patient has almost invariably headache, of a heavy aching, or throbbing character, located in the forehead and over the eyes, or in the temples, and very often on the left side only. She is easily upset in emotions and gives way to tears for trivial causes.—*Ibid*.

APOCYNUM CANNAB. IN LOCAL DROPSY WITH CONSTIPATION.—Miss X., a young woman, whose ovaries and tubes had been removed about two years ago, suffered from an increasing size of the hips, the circumference of which had increased six inches during the last month. The hypogastric region had also enlarged. There was also an obstinate constipation, which no purgatives would affect. When a stool was had, it was composed of small, hard balls, coated with mucus. The urine was very scanty, and of a dark yellowish-brown color; there was no swelling of

the legs, feet or face. After trying apparently indicated remedies without effect, Boericke & Tafel's decoction of *apocynum cannabinum* was prescribed, a teaspoonful every four hours. During the first two days there was much nausea and vertigo. On the third day the bowels moved several times, and an increase of urine was observed. From this time there was a steady improvement. In ten days the local dropsy had disappeared, also the constipation.—*Homœopathic Recorder*, Sept., 1893.

IS CALENDULA AN ANTISEPTIC?—Dr. Bishop cites several cases of septic wounds, in which he obtained most satisfactory results by the use of *calendula* tincture. In one of them, an abscess, bi-chloride of mercury solution (1-2000) had been used for a week, with but slight diminution of the discharge. *Calendula* irrigation was substituted, and in a few days the discharge had dwindled down to a few drops daily, and the cavity rapidly closed by granulation. In two other cases the wounds were undoubtedly septic, one being caused by a cow's horn, and the other by a falling branch of a tree. In both of these, *calendula* dressings were applied after the wounds had been carefully washed with hot water, and in each instance primary union was obtained.

Dr. Bishop concludes: "Such cases as these could be easily multiplied, and are, doubtless, familiar to all homœopathic physicians. Do they not indicate that *calendula* is germicidal in its action? Certainly in these cases the wounds were all septic, and the use of *calendula* locally was followed in one case by rapid cessation of the secretion of pus, and in the other two by no pus at all. The suggestion might be made that its action is not germicidal, but that it prevents and suppresses suppuration by stimulating the animal cells with which it comes in contact, so that they are able to resist the attacks of the pyogenic organisms."—*Pacific Coast Jour. of Homœopathy*, June, 1893.

"THE HANDS OVER THE HEAD."—Some women, in sleeping, have their hands over the head. This indicates a remedy; it also sometimes denotes a tendency to falling of the womb. The remedy most prominently indicated is *puls*. From uterine disease, women often have palpitation of the heart; *puls* will relieve this. *Nux vom* is the next best remedy for the condition of putting the hands over the head in sleep; it is better for the man, *puls* for the woman. *Ara*, *bell*, *platina* and *calc. carb* are also indicated for the hand under the head. In asthmatic conditions or dyspnoea, when the hands are placed over the head, *nux vom* is indicated. *Platina* is to be thought of in this condition when there is also extreme tenderness on the genital organs.—Dr. Frank Kraft (*Am. Hom.*)

A PROVING OF CIMICIFUGA.—Dr. J. N. Brainard, of Alma, Mich. in the *Therapeutic Gazette*, reports his experiments in obtaining the physiological action of *cimicifuga racemosa*. It is interesting as a confirmation of homœopathic provings, in everything except the production of priapism, which, we believe, has not been generally noted, though it would not be unexpected in view of the well-known action of the drug on the lower segments of the spinal cord:

"On November 26, I took three drachms of the fluid extract of *cimicifuga*, and in about half an hour had a feeling of fulness in the head; the face was flushed; there was a sensation of warmth all over the body, without vertigo, which was increased in the erect posture. There was also considerable pain at the end of the spine. After an hour had elapsed, these symptoms were accentuated. There was redness of the eyes, but the pupils were normal, as was also the bodily temperature. The pulse was 100 and full, and there was a marked increase in arterial tension. At no time was there a slowing of the pulse or any sign of cardiac depression. The headache now became excessively severe, and the spinal cord was apparently much stimulated. The muscles of the back, arms and legs were hard and trembling. Two hours later these symptoms continued with increased severity, and nausea was added. There was increased peristalsis, but no purging. Four hours after taking the poison I drank some warm water, and vomited three times during the next five hours. The symptoms continued, nevertheless, until the eighth hour. The headache was so exceedingly severe that it was necessary for my wife to chloroform me. There was a great deal of backache and restlessness. Eight hours after the poison was taken, sleep came on, from which I waked several times with marked priapism. The effects upon the spinal cord and nerves were felt for a little over two days. There was considerable increase in bronchial secretion. There was no increase in urinary flow or in the secretion of the skin during the entire period of the paroxysm."

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THE TREATMENT OF ŒSOPHAGEAL STRICTURE BY ELECTROLYSIS.

BY WILLIAM HARVEY KING, M.D., NEW YORK CITY.

(Read before the National Society of Electro-Therapentists, September 26, 1893.)

THAT we may more readily comprehend the indications for treatment by electrolysis and the results which may be expected from it, I will divide the various kinds of stricture of the Œsophagus into four classes.

First.—Fibrous stricture, caused by some inflammatory process in the Œsophagus itself or some neighboring tissue.

Second.—Cicatricial stricture, which is either caused by swallowing some corrosive liquid or the result of the healing of some deep-seated ulceration of the mucous membrane and sub-mucous tissue.

Third.—Cancerous stricture.

Fourth.—Spasmodic stricture.

The symptoms of Œsophageal stricture are quite uniform in their character. They begin with difficulty in swallowing meats, which may be first noticed when the patient is eating in a hurry. This difficulty increases until only liquid food can be taken, and sometimes even that is swallowed with the greatest difficulty, and unless the patient is careful to not irritate the Œsophagus, he may have to fast for hours at a time. Sometimes the tube above the stricture becomes so dilated that it acts as a reservoir and the patient will

swallow considerable food, thinking it has entered his stomach, when it suddenly will return. If the stricture is high up, the food will return very soon after being swallowed; but if near the lower end of the tube, it may remain hours before being returned. The health declines in proportion to the interference with the nutrition, until the patient, who might have been robust, becomes a walking skeleton, presenting a perfect picture of starvation.

In examining a case of stricture of the œsophagus for treatment, care should be taken to determine the cause of the stricture. That it is cancerous does not necessarily contraindicate treatment, for it will be seen later that the results, so far as opening up the canal and allowing the patient to take nourishment is very satisfactory; but of course, the prognosis, so far as saving the patient's life is concerned, is not good. One should always be cautious in giving a prognosis regarding the permanency of the cure, if there is a large spasmodic element, unless the spasmodic condition is produced by a small fibrous stricture at the same place, or it is due to a fibrous stricture either above or below the spasmodic one, in which case, if you can cure the fibrous stricture, you can generally relieve the other; but it is those cases of spasmodic stricture which are due to some general or outside cause which a treatment by electricity does not permanently relieve. Care should also be exercised in determining whether the obstruction is due to the pressure of a tumor on the œsophageal wall, thus closing up the canal. In other words, be sure that there is a stricture involving the mucous membrane of the œsophagus where the catalytic action of the current can act direct upon it. This can nearly always be done, for the diagnosis of stricture of the œsophagus can easily be made by careful examination. It differs from spasm in the fact that it comes on gradually, taking months or even years before obstruction is complete and has reached this point by gradual stages. With spasm the obstruction is sudden in its onset and as suddenly disappears. It is intermittent. Anti-spasmodic remedies relieve it at once. The passage of a bougie in a spasmodic stricture either meets with no obstruction, or if it does, slight pressure on it for a moment causes it to give way. Such is not the case with fibrous or cicatricial strictures. Paralysis and dilation of the œsophagus may produce the difficulty of swallowing and regurgitation the same as stricture, but the passing of a bougie determines the difference. The possibility of a tumor, either post-pharyngeal or thoracic, should be excluded by a proper examination of those parts. If the stricture is cancerous, blood will generally

be found on the regurgitated food and will nearly always be found on the bougie when it is withdrawn, no matter how gently the examination has been made. The general symptoms of cancer are also present.

It is difficult to diagnose the difference between fibrous and cicatricial stricture with the bougie. The history of the case, however, will generally help in deciding this point.

After the nature of the stricture has been diagnosed, and found to be amenable to treatment, and the size of the opening measured, an electrode one size larger than the calibre of the stricture should be selected for the treatment. I wish to say here, I have had a set of these electrodes made after ideas of my own, beginning with one four millimeters in diameter, and increasing one millimeter with each bulb—the last one being twenty-four millimeters in diameter. These bulbs are made so that they can be screwed to a flexible stem, twelve inches in length; which, in turn, screws into a firm handle. The flexible part can be bent into any shape which may be desired, while the handle furnishes a strong grasp for the hand. On this handle are marks which indicate the number of inches the stricture is from the teeth. For a small sum each bulb can have a separate flexible stem soldered to it; but, if care is exercised to have the bulb firmly screwed on, there is no danger of leaving a bulb in the stomach. These bulbs are numbered from 1 to 20, and are a slight modification of the ordinary olive-tip—being made in a perfect oval. Most of the olive-tipped instruments of this kind have quite a shoulder on the end that attaches to the stem, and, consequently, are very hard to withdraw. I have used bulbs of this kind, and attained very unsatisfactory results; for, where a stricture is at all spasmodic, and the contractions above this shoulder are such as to necessitate force to withdraw the bulb, an irritation may follow that will greatly aggravate the spasmodic condition for days or even weeks. In introducing these electrodes, care should be taken to do so very gently, for rough handling will cause irritation. If there should be considerable resistance to the passing of an electrode, the same one should be used for the next treatment, instead of going to one of a larger calibre; but, if it should go through comparatively easy—say, with from 4 to 6 milliamperes, and under gentle pressure, in from two to five minutes—one size larger can be selected for the next treatment. It will often be found, however, in very slight strictures, that even two sizes larger can be used at a subsequent treatment.

The clinical part of this paper is based on an experience of six cases. Of these, one was cancerous; one was largely, but not entirely, spasmodic; one was cicatricial, due to the swallowing of a corrosive acid; and the other three were undoubtedly fibrous. One of the latter was distinctly traceable to a very severe attack of bronchitis and trachitis, the inflammation extending to the œsophagus. The other two were of uncertain origin. All, with the exception of the cancerous and the cicatricial strictures, were situated immediately behind, or just below, the cricoid cartilage. There were four distinct contractions from the junction of the upper and middle third of the œsophagus to the cardiac opening, in the cancerous case, and a roughness of the intervening space could be distinctly felt on introducing a bulbous sound, thus distinguishing it from a fibrous stricture, which has a smooth surface with a distinct band as the stricture. It was also impossible to introduce a sound of any kind in the cancerous case without bringing out with it more or less of a sanguinous discharge; whilst this never occurred on gentle manipulation with the others. The one which was largely spasmodic was thought, at first, to be entirely so; but, when a No. 8 sound was introduced, its progress was resisted, and, unlike a spasmodic stricture, which, after slight pressure, yields, it was impossible to pass the bulb beyond that point.

CASE I.—Mrs. C., aged 50 years, had a fibrous stricture about one inch below the cricoid cartilage. It had been dilated by passing bougies on several occasions, but with only temporary relief. I began with the smallest sized electrode (No. 1). She was treated once a week for three weeks, increasing one size each week. After passing a No. 3, decided improvement was noticed in swallowing. She was then treated once in two weeks, increasing one number at each treatment until a No. 7 was passed. When this patient commenced treatment she was so weak from inanition that she could hardly get to the office. She was only able to swallow liquids, and this with the greatest difficulty. After a No. 3 was passed, liquids were swallowed with perfect freedom, and, after a No. 5 had been passed, nearly all kinds of vegetables could be taken. It was only necessary to be cautious about chewing the food and to swallow slowly. She did not improve so that she could swallow meat, for with the passing of a No. 7 œsophageal treatments were discontinued, and an operation on the rectum was performed. This was immediately followed by another severe illness, and this has kept her confined to her bed most of the time, and no more treatments

have been given, but, with all her suffering, the stricture has never apparently closed up, as she can swallow as well as she could at the last treatment, which was on September 2, 1891, and there is no trouble to keep her well nourished. This case illustrates the permanency of the result of this treatment. This was undoubtedly a genuine fibrous stricture, possessing the least of a spasmodic nature of any I have ever seen.

CASE II—Mrs. R. This is the case I mentioned as having been caused by extension of inflammation from the trachea. It was thought at first to be spasmodic, but a No. 8 bulb was resisted, and from the passing of this up to the largest size we met with an organic contraction, but the spasmodic element was strong during the whole treatment. I began on October 20, 1892, with a No. 4, but, as there was so little resistance, I quickly went up to No. 8, when, as stated above, the resistance of an organic stricture was found. I treated with a No. 8 on December 2d, and once a week after for five weeks, increasing one size at each treatment. If there happened to be any little hitch in the treatment, such as the electrode sticking in the stricture, there would be a spasmodic irritation for some days following it. She was very nervous, and frequently I would scarcely get the electrode in position before I would have to withdraw it, and on this account I was frequently obliged to use the same electrode that I had used at the previous treatment, as she could not retain the size larger long enough to let it work its way through. One day the patient was so nervous that I had to repeat a previously used electrode, put it through and withdraw it very quickly. I thought I would use a stronger current and see if I did not get the same effect as I did with a weaker one continued a little longer, so I turned on 12 milliamperes. This, I am sorry to say, did not work to my satisfaction, for it set up such an irritation that the patient did not regain in three weeks the condition that she was in before the treatment. A similar result, only not so severe, was produced by trying to insert too large an electrode. This I have also noticed in other cases. After this, treatments were given more cautiously and at less frequent intervals without further trouble. This patient was much emaciated when I first saw her, and was fasting twenty-four hours at a time, but after a No. 8 had been passed she swallowed nearly all vegetables quite readily, except the two occasions I mentioned above. She was never able to swallow meat well. I expect the least permanent result in this case of any I have treated on account of the spasmodic and irritable conditions.

CASE III.—Mr. M. This is the case of cancer. When I saw him first, December 2, 1892, he had not been able to swallow any kind of liquid for forty-eight hours, and was so weak and emaciated that he could hardly walk. In making the examination I found I was unable to get down even the No. 1 electrode. I then attached the electrode to a battery and gave a treatment, using six milliamperes, when it passed through in one and a half minutes. After waiting for thirty minutes I passed a No. 2 in the same way; after this he managed, with great difficulty, to drink a pint of milk. On account of the critical condition of this case, I treated him again in three days. He had been able to drink milk with difficulty during this time. At this treatment I increased two sizes, the same as I did before, with considerable improvement in his swallowing. One week from the second treatment I treated him with a No. 3 and a No. 4, the following week getting up to a No. 6. There had, however, been no improvement in swallowing after the second treatment, and just before he came to me for the fifth time he found the same trouble in swallowing that he had before the first treatment. On examination of the stricture I had been treating, which was located just posterior to the cricoid cartilage, I found that it readily admitted a No. 6. This led me to examine further down, and here I discovered the trouble before described, and which led me to diagnose a cancerous condition of the œsophagus. The fourth stricture, which was just above the cardiac orifice, was the troublesome one. I treated this the same as I did the upper one at first. After I had passed a No. 2 he was again able to swallow, with difficulty, another pint of milk. I continued treating the stricture once a week for six weeks, when a hæmorrhage of the bowels, due to another cancer in that region, carried him off. During the last two weeks of the treatment he was able to swallow liquids and thin gruels readily, but was never able to swallow vegetables. This was undoubtedly due to the number of strictures, and also to the diseased condition of the wall of the œsophagus, it having lost its contractile power. Before I saw this case, several attempts had been made to dilate, and although large rubber bougies had been forced down the œsophagus, it did not relieve, but on the contrary aggravated the difficulty of swallowing, and he was obliged to fast for from 24 to 48 hours after each treatment.

CASE IV.—Mr. A., aged 60. Stricture of four years' standing. I first examined him January 10, 1892. The stricture was located about one inch below the lower border of the cricoid cartilage. It

admitted a No. 2 bulb on slight pressure, consequently a No. 3 was used in giving the first treatment. Treatments were given once a week, with a corresponding increase in the size of the electrodes used until the largest size was passed. There was not a single drawback to the treatment. He was taking only liquid food when I first saw him. After a No. 6 had been passed, he could eat some vegetables. After a No. 11, he was able to eat some meat, and has been eating everything since discontinuing the treatment. Dilation had been tried on this case without even temporary relief.

CASE V.—Mr. P. A simple case, very similar to Case IV. The only separate point of interest regarding it, was that there was a dilatation just above the stricture, which had formed into a slight pouch of the posterior wall, so that great care had to be exercised in order to prevent the electrode from getting into it instead of engaging in the stricture. This was easily done by so bending the flexible part of the electrode that the bulb ran down along the anterior wall, and thus avoiding the posterior sac.

CASE VI.—Female, æt. 32. This is the case that was produced by swallowing a mixture of sulphuric acid. The acid was swallowed July 5, 1891. As soon as she began to recover from the active effects of the acid, a difficulty in swallowing was noticed. This gradually increased until I saw her in December of the same year. At this time she was swallowing liquids with the greatest difficulty, and it was evident that if something was not done soon to relieve her, it would not be long before the ability to swallow would cease altogether. Bougies had been passed and gave no relief whatever. I was informed that the stricture was located about eight inches from the teeth. I here found a stricture, but, as it offered only temporary resistance to the passage of one sound after another, I concluded it must be more spasmodic than otherwise. I then passed the sound down to within about two inches of the cardiac opening and here I found that a No. 1 sound could pass on slight pressure, but not a No. 2. The battery was then attached to this electrode and, using five milliamperes of current, it went through in one minute and a quarter. The same treatment was given once a week for eight weeks, only increasing six numbers, as the resistance was greater than that in any other stricture I had treated. At this time, after the passage of a No. 8, she could swallow a few vegetables; but it was not until a No. 11 was reached that she could swallow vegetables that a patient with a stricture located higher up could swallow after the use of a No. 6. Twenty-six treatments were given when a No.

16 had been passed. At this time she was able to swallow meat, and was practically cured.

I have seen this case lately—one year and a half after the treatment was discontinued—and she remains perfectly well.

This case is a very instructive one, as, first, it would seem to show that a stricture produced by swallowing acids, etc., is lower down than when it originates from other causes. I would say that in looking over the history of cases, this fact has been corroborated. Second, that an organic stricture can, by reflex action, produce a spasmodic stricture, and that, when the organic is cured, the spasmodic disappears without treatment; or, at least, this was what occurred in this case, as there was no treatment given, unless the passage of the electrode through it without the current was called a treatment. Third, that the lower down a stricture is, the more difficulty there is in swallowing, or, in other words, the calibre of the stricture must be larger than one higher up in order to swallow vegetables.

All these cases came to me in a greatly emaciated condition, they only being able to swallow liquids, and those with difficulty. All were greatly improved and were able to eat, so that their bodies became well nourished, except, of course, the one with the cancer; but, even in his case, the swallowing improved and continued so until his death. These cases all had the same history, dating back from five months, as was the case with the last one, to four years. All first noticed that they swallowed meat with difficulty and finally had to cease eating it altogether. Then certain vegetables had to be, one by one, discontinued, and finally, the patient was confined to liquid food alone. When the patient begins to improve, very thin gruels may be given. They should be thoroughly cooked, as a few hard kernels of oatmeal, hominy, or rice will produce an irritation. Now finely masticated bread and milk may be given, then a little solid food. From this time bread and butter may be given. Spinach is the last vegetable that should be tried. When the patient gets so he can eat meat readily, you can consider his case cured. Great caution should be exercised when the patient gets so he can eat well, for the long fasting has got the stomach in a delicate condition, and the ravenous appetite which hunger produces is liable to cause him to overload his stomach and produce serious results. I might mention in a comparative way that in four of these cases dilatation had been tried without success, and two were aggravated by it. I believe that if a pure spasmodic stricture exists, dilatation may help it, but it will not if there is any real contraction.

ARBORIVITAL MEDICINE.

BEING AN INQUIRY INTO THE CURATIVE POWERS OF SOME OF
OUR COMMON FIELD AND GARDEN PLANTS, JUDGED
OF BY THE DISEASES OF THE EAR.

BY ROBERT T. COOPER, M.A., M.D., LONDON,

(Continued from September, 1893.)

VIOLA TRICOLOR. CHEIRANTHUS CHEIRI.

IT is often said that the formulation of doctrines in religion has done more to curtail and warp the beneficial influence of true religion than any single factor. Yet in the absence of doctrine it is impossible to conceive of a religious system. A like remark applies to medicine; the formulation of doctrine may tend to narrow unduly the prescriber's sphere of action, even while most desirable in the interests of uniformity and cohesion. The fact is that just as religious sects are tolerating much greater latitude of expression in the matter of doctrine, so must the sect of sects in medicine, Homœopathy, allow a freer hand to her adherents in the application of doctrines usually considered homœopathic. Hahnemann has pointed out the necessity for giving one remedy at a time, and carefully observing its action and selecting it on the principle of similars; all of which is eminently scientific.

My principal divergence from this scheme consists simply in taking upon myself the liberty to administer on occasions a remedy without being able to prove that any similitude exists between its symptoms and those of the disease to be cured, and in my insistence even more than Hahnemann did upon the solitary dose in the obstinate chronic affections, such as are, undoubtedly, those of the ear. I refer to this because some of my friends make almost as much complaint at my not giving up the Homœopathic Hospital altogether as they used, some years ago, to do at the absence of clinical teaching therein. Complaint like this goes for very little as long as their own liberty of action is not interfered with. It will be an evil day for the Homœopathic Hospital when its staff acknowledge their unwillingness to use all fairly legitimate means of investigating the action of drugs, amongst which means clinical investigation must take a prominent part. Be this as it may, the aim of all of us ought to be to make inquiry into the forces of nature in the interests of the

sick, and not to impede progress by useless discussion. Each practitioner should be, in spite of adverse criticism, the keeper of his own conscience, and adopt the method he finds most successful of drug selection. If any of us effect a cure of an obstinate case of disease with a single remedy, I hold, with almost all true homœopaths, that such a case ought to be reported, and, further, that until the reporter has good grounds for pointing out what feature in the case constitutes an indication for the remedy, he had better not pronounce absolutely upon it; while if some purely fanciful reason has led to the selection of his remedy, I hold it to be better to state this in a plain and unmistakable way than to remain silent in order to please the hypercritical. As long as the prescriber does not attach undue importance to the reasons for his selection, the mere statement of these reasons can do no harm.

Primitive races have furnished us with very valuable remedies—remedies that were selected by them on the doctrine of signatures, or for other reasons that now-a-days appear to us as absurdly ridiculous; yet when proved, these very drugs have in every case been shown to bear a homœopathic relationship to the diseases curable by them. Our provings reveal a large number of ear symptoms; admit that nearly every remedy that has been proved acts upon the ear, and admit also a crushing defect in the practical application of our system of pathogenesis. If such symptoms are true expressions of drug action, then why is it more use is not made of them? Those who condemn me for my mode of procedure ought, in reason, to show, from their own practice, the reliability of such symptoms as guides to the acquisition of specifics in ear cases. This has never been done on a scale commensurate with practical requirements, and for the simple reason I have stated in the articles “One Dose, One Value” and “The Frequency Law” of February and March, 1893, in the *Homœopathic World*.

The last remedy, *viola odorata*, upon which I dwelt was brought under my notice in a very simple way. A professional lady singer, in the course of conversation upon our garden plants as remedies in disease, told me that on first interviewing a noted prima donna, the latter rushed at her the moment my friend entered, and plucking a bouquet of violets from her dress, threw it out of the window, with the exclamation, “You’ll never sing as long as you keep those there!” The idea suggested itself to me, from this, that the violet possibly disarranges the entire vocal apparatus, and thus led me to make trial of it.

In a man of about forty, whose ear had not discharged for about seven months after *viola tricolor* &A., a pain came in the left eustachian tube, and then this ear discharged with a trickling sensation inside the ear for three days, and then dried up—showing, as our provings had already done, a strong relationship between the odorator and tricolor varieties of the violet.

Our next remedy is the common wallflower (*cheiranthus cheiri*) a tincture made from the single dark-flowered plant. No proving of this remedy has come under my notice, yet I consider the following case worth reporting:

T. T., age twenty, a clerk; admission-date, 30th April, 1892; never heard well on the left side, but particularly deaf the last month, and deafness increases; watch hearing, contact only. History of much earache in childhood; left ear discharges, but the discharge does not run out. Wisdom teeth; left upper and right lower and upper breaking through. *Cheiranthus cheiri*, &A.

28th May, hears very much better; left, $3\frac{1}{2}$ inches. No medicine. 11th June, continues improving gradually; left, 15 inches. 25th June, continues to hear voices very fairly on the left side, but no improvement since last time; left, 15 in. *Cheiranthus cheiri*, &A.

25th July, restoration of improving condition; left, 20 in. No medicine.

6th August, 1892, getting on very well; hearing in every way satisfactory; left, 25 inches.

From this it would appear that towards the end of about six weeks the effects wrought by the remedy had become exhausted, for from the 30th of April to the 25th of June no dose was given, and improvement seemed to cease about the 11th of June. Immediately after the dose of the 25th of June improvement again began. The case most certainly proves, as decidedly as it is possible to prove such a matter by a single case, that the solitary uninterfered with dose is the best method of giving remedies in deaf cases, for during many years of experience in these cases I have very seldom, if ever, completed a cure of such a form of deafness by repeated dosing. It is too soon to say what is the indication in the case for *cheiranthus*; the fact of the wisdom teeth erupting may perhaps be an indication—for in another case that dated three years back to measles, and in which the wisdoms were barely showing through, in a girl of twenty-two, it has unaided improved the hearing in a way similarly to the above.

Should this be the indication, it allies *cheiranthus cheiri* with

magnesia carbonica, though the symptom "the wisdom teeth make their appearance" gives us but scant support for prescribing magnesia in the deafness accompanying this adult dentition. Cheiranthus cheiri "A. took away at once a pain in the lower back, with jaundiced appearance and bilious feeling accompanied by sickness of stomach, for which the patient, a girl of about twenty, was in the habit of taking purgative pills.

This completes my observations up to the present on the common wallflower. It may be interesting to turn up Culpepper, and see what he has to say on the subject of the wallflower :

"Government and virtues. The moon rules them. Galen, in his seventh book of simple remedies, saith that the yellow wallflowers work more powerfully than any of the other kinds, and is therefore of more use in physic. It cleanseth the blood and freeth the liver and reins from obstruction, provoketh women's courses, expelleth the secundine and dead child, helpeth the hardness and pains of the mother, and of the spleen also ; stayeth inflammation and swellings, comforteth and strengtheneth any weak part or out of joint, helpeth to cleanse the eyes from mist or films over them, and to cleanse foul and filthy ulcers of the mouth or any other part, and is a singular remedy for the gout and all aches and pain in the joints and sinews. A conserve made of flowers is used for a remedy both for apoplexy and palsie."—Culpepper, p. 258 ; *The English Physician*, London. John Streater, 1666.

30A, GEORGE ST., HANOVER SQUARE, LONDON, W.

THE MEDICAL TREATMENT OF APPENDICITIS.—Terry (Utica, N. Y.) directs attention to the medical treatment of appendicitis, and "the superiority of the oil treatment over the knife." The time when this is most appropriate is the interval in the early stage when the surgeon hesitates to use the knife—the first twenty-four hours—and the patient refuses to undergo the operation.

The first procedure is to thoroughly evacuate the bowels, preferably by castor oil, if the patient can take it, 2 to 4 drachms being administered every three hours. If this cannot be retained and the case is urgent, Dr. Terry gives from 5 to 10 grains of calomel with 20 to 30 grains of bicarbonate of soda, in a glass of water, repeating in three to six hours until a thorough evacuation ensues.

In cases of absolute obstruction he makes use of the following: Fleming's solution of atropia, gtt. 10 (representing $\frac{1}{80}$ of a grain); acid sulphuric, gtt. 10; tinct. aurantii cort., dr. 1; magnesia sulph., dr. 1; aqua, oz. $\frac{1}{2}$. This to be given in the morning, and the same without the atropia at night. If the case be very urgent, give this dose without the atropia every three hours.

If remedies cannot be retained in the stomach, give an enema of 4 to 6 ounces of sweet oil, to be followed by a warm alkaline solution of bicarbonate of soda, dr. 1, to a quart of water. The pelvis should be elevated.

As auxiliary treatment, keep constantly applied to the abdomen a hot flaxseed poultice over which has been poured hot sweet oil. The same treatment holds good in cases of absolute obstruction, strangulated and incarcerated hernia.—*Journal of Official Surgery*.

Vesical Calculus—Natural Size.

THE SUPRA-PUBIC REMOVAL OF AN ENORMOUS VESICAL CALCULUS,
TOGETHER WITH THE PATHOLOGY OF STONE IN THE BLADDER.

BY CARL V. VISCHER, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society, State of Pennsylvania, Sept. 19, 1893.)

UNDER ordinary circumstances, at the present day, one would scarcely be warranted in reporting so common a procedure as opening the bladder through the supra-pubic route, at least not unless the report embodied the results of a large number of consecutive cases; and even then one would feel like offering an apology, as the *sectio alta*, having had its fluctuations, has probably, in the minds of most, found its permanent level.

So it is with no intention of eulogizing an operation which, from experience, is, to my mind, undoubtedly, the simplest and safest method of entering the bladder, but merely to record a case which, to the best of my knowledge, is unique as to the size of the stone.

Dr. White, in the *Annals of Surgery*, reports a case of "Supra-Pubic Removal of an Enormous Vesical Calculus," in which the stone weighed $9\frac{1}{2}$ ounces and measured $8\frac{1}{4}$ inches in its largest circumference. The case I here desire to record is one in which the calculus weighed 10 ounces and 60 grains and measured $9\frac{1}{2}$ inches in the largest and $8\frac{1}{4}$ inches in the smallest circumference, making it the largest stone removed without fragmentation that I could find recorded. There were some points in the history of the case which make it worth reporting in full.

A. W., æt. 33, American, cigar maker by trade. Personal history, as well as that of his family, is negative as pertaining to his illness, save that when a child of 15 he suffered occasionally from a frequency in urinating which was accompanied by some pain and once by some little blood. These attacks of dysuria were attributed to cold, and treated accordingly, and never affected his general health in any appreciable manner. His habits have always been good, leading, necessarily, a sedentary life. Some three years since he was taken with a very frequent desire to urinate, which was accompanied by more or less pain and some cloudiness of the urine. This was believed to be due to cystitis, for which he was treated as the attacks occurred, until the early part of April, when the trouble appeared in an aggravated form. He came under the care of my colleague, Dr.

W. H. Middleton, who at first believed him to be suffering from acute prostatitis. A rectal examination having revealed a large tumor on the right side, which was very sensitive to the touch, treatment directed for this soon brought about amelioration, which, however, was but temporary, the symptoms reappearing shortly very much aggravated. This led to a careful examination, when, on attempting to pass a sound into the bladder, it came to a sudden stop as it reached the prostatic urethra. On carefully guiding it, however, it passed into the bladder, and in doing so revealed the presence of a stone on the right side, which immediately gave the impression as being one of considerable size, it having been fast and immovable. A finger in the rectum at the same time as the sound was in the bladder proved the swelling previously detected to be due to the presence of the calculus. Its removal was of course recommended, and, after the ordinary preparations, effected by way of the supra-pubic route. This method was chosen for the reason that it was believed the stone was of good size and also owing to my preference, it being, without doubt, the simplest, from my own experience, as well as that of my colleagues; its two greatest dangers being more theoretical than real. I have reference to wounding of the peritonæum and urinary infiltration. The former need not be dreaded should it occur, and the latter, with careful drainage and strict attention to cleanliness, although possible, is most improbable. The technique was somewhat out of the usual. The bladder holding but little water, it was impossible to distend it to any extent, and owing to the position of the stone, a sound could not be passed into the bladder sufficiently far to allow depressing the handle so as to make the beak prominent. The bladder was therefore cut down upon without a guide. The peritonæum (unusual in my experience) was found to completely cover the organ. Having carefully dissected it from the under surface of the pubis, it was pushed up out of harm's way and the bladder opened by an incision down on the stone, which could easily be felt. On introducing a finger and determining the sized calculus, the incision was enlarged downward as far as possible. The stone, which was firmly imbedded in the "cæcal pouch," was dislodged with some little difficulty, when it was found that the bladder opening was too small for its delivery; it was accordingly enlarged upward, care being taken to guard the peritonæum by holding it well out of the way with a finger. Having opened the bladder to the fullest extent possible in one direction, and still being unable to deliver the stone, it, together with the right

rectus muscle, was incised laterally to the extent of half an inch, after which delivery was effected.

The manipulations necessitated in removing the calculus were very perceptible on the condition of the patient, who stood the operation perfectly until extraction was attempted, when the pulse immediately began to flag and the patient show signs of collapse. The lateral incision through the bladder and muscle was united by a suture of silkworm-gut, and after thorough irrigation with Thiersch's solution, a modification of Trendelenberg's drain was introduced, and the wound dressed in the usual manner. As previously stated, the patient showed marked signs of collapse, though the procedure was executed with as much celerity as possible, the operation itself lasting twelve minutes and the patient being under the influence of ether twenty minutes.

After some little stimulation reaction set in from which time on recovery was rapid and uneventful, save that there was, with the exception of a very little connective tissue, no sloughing whatever. The wound showed great tendency to rapid repair, the drain was removed on the third day and on the eleventh urine began to pass through the urethra. The wound being completely healed in less than a month, since which the patient has been enjoying perfect health feeling better than for years previous.

A point in the history of this case which at first would seem rather unusual is the almost total absence of cystitis. The urine, at the time of the operation having been perfectly clear on voiding, and after allowing to stand depositing but little mucus, no pus to speak of and some phosphates. At no time was it specially cloudy. This though it at first appears strange, explains itself to my mind, in that, the stone so completely filled the cavity of the bladder that it produced comparatively little irritation. Another interesting point would be the age of the calculus, though it is known that the size of a stone has no relation to its age, in this particular instance there is reason from the history, and character of the stone, which undoubtedly is uric acid covered by phosphates, that its formation dates back to the period of childhood. In the literature at my command, I was able to find but little as to the size of vesical calculi, save the one already quoted. The largest mentioned as having been removed without fragmentation, range from three to six ounces in weight. Dr. Thomas having extracted one weighing six ounces and Dr. James* removed one from a female which weighed over five ounces.

* HAHNEMANNIAN MONTHLY, January, 1891.

As to the pathology of vesical calculi we know that as a rule the nuclei are formed in the kidney and are either composed of blood clot or desquamated epithelium, around which the various urinary salts are deposited or they are composed entirely of the salts, principally uric acid. On reaching the bladder they for various reasons may be retained. In that they may be too large to pass through the urethra, or they may be precipitated into a diverticulum or between the folds of the vesical mucosa where their size gradually increases as the solid matter of the urine becomes deposited. At times though less frequently they originate in the bladder itself, when we find the nucleus to be composed of blood clot, mucous, or desquamated epithelium, as those formed in the kidney, or as is more often the case, when the stone is primarily a bladder one the nucleus is formed by a foreign body which has found its way into the bladder, such as a piece of catheter, remnants of dermoid cysts, such as teeth, bone which may reach the bladder through ulcerative processes, gall-stones and the greatest variety of objects. I recall an instance where a hair-pin formed the nucleus of quite a large stone removed from a female. Stones vary in size as they do in variety. They are, however, most commonly found singly, and may range in size from that of a pea or smaller to that of a goose egg, instances having been observed where the calculus formation reached between one and two pounds in weight. The smaller the calculi the more apt are they to be found in numbers, that vary from a few to several hundred. Their form is either round, ellipsoid, or flat; less frequently they have the form of an hour-glass or pipe-stem and still rarer are they angular or faceted, resembling those of biliary formation. In appearance they most commonly present a granular surface, and are of a yellow, brownish-yellow, gray, grayish-white, or black color, much depending on the character of the formation. In consistence, they are all more or less hard, varying from great brittleness to stony toughness. On section it is seen that they are not uniform in their structure, but composed of several salts, which are deposited in one or more layers or strata around the nucleus. It is only exceptional that a calculus is found to consist of a single salt.

We recognize a number of varieties in accordance with their composition. The principal ones being uric acid, phosphate, oxalate, and carbonate of lime, cystine, xanthin, and indigen.

The uric acid stones are possibly the commonest, and are found either singly or in numbers and may be round, oval or flat; the surface presents a smooth polished appearance or it may be finely

granular. They are of a dark-brown or reddish color, depending on the quantity of coloring matter that enters into their formation. A polished section shows them to be in concentric layers. At times we find the nucleus composed of oxalite of lime, as also we find in oxalate stones the nucleus consisting of uric acid.

In early childhood and old age stones composed of the urates of ammonia and soda with more or less uric acid are not infrequently found.

These seldom attain a larger size than an English walnut and are mostly round or flat in form, and of a dark-brown or yellow color. When dry they are quite brittle.

Phosphatic calculi are almost, if not quite as common as the uric acid variety, and are composed either of the phosphate of ammonia and magnesia or as happens more often of triple phosphates, with more or less uric acid and oxalate of lime. They frequently have a foreign body or oxalate of lime as a nucleus. The pure phosphatic stone is as a rule not as large as those of a mixed composition. In color they are mostly a dirty white, gray or yellow. The surface is usually granular. On section it is seen that they are either homogeneous or more or less porous. Phosphatic calculi are of a light specific gravity and very brittle. Alkaline urine predisposes to their formation. Stones composed of oxalate of lime occur oftenest in youthful individuals and in some regions are quite common, though as a rule they are less frequent than either of the aforementioned varieties. At times they attain a large size but generally are found to be about the size of a pigeon egg or smaller.

They are usually round in form, with more or less granular surface, which, when marked, has given the stone an appearance not unlike a mulberry, and hence the name "mulberry calculi." They are very hard in consistence, and when mixed with uric acid, as frequently happens, present the hardest variety of vesical calculi. They are also found multiple. On section, they show a striated appearance, and not uncommonly contain several nuclei. In color they resemble phosphatic stones. Carbonate of lime stones, as such, occur but rarely in man, whereas they are commonly found in some of the lower animals. They are usually about the size of an English walnut, of a yellowish-gray color, with an iridescent metallic lustre. Stones formed of cystine are among the rarest, and little is known of their composition save that they are found in connection with cystinuria. They are of a yellow, waxy color, and in appearance more or less smooth. They have been repeatedly found in members

of the same family without any inherited predisposition. Xanthin stones are of equal rarity with those of cystine. They are either found to consist purely of xanthin or in combination with oxalates and phosphates. In color they are of a dark brown, with a smooth surface. In consistency they equal those of uric acid formation. In connection with these calculi of rare formation, there yet remain several others to consider. Stones in the most part composed of indigen, which are recognized by their dark bluish color and soft consistency, together with the coloring matter, contain more or less phosphates. Those that are made up of urates, cholesterine, and fat, with a greater or less amount of oxalate and carbonate of lime, have been termed uroliths. Finally, there are the so-called blood-stones, which consist of a coagulum through which has been deposited lime salts. Thompson's statistics of 500 stones show 313 to have been uric acid, 99 phosphatic, 50 with uric acid nuclei and phosphatic covering, 16 oxalate, 9 with oxalate of lime nuclei with uric acid, 6 oxalate of lime with phosphates, 1 cystine, 1 of phosphate of lime, 1 of phosphate and carbonate of lime, and 4 phosphatic, with foreign bodies as nuclei.

The ætiological factors productive of lithiasis are not, in all instances, the same, save that it is essential for many that some organic substance is present which forms the foundation for their further development. This is shown in that urine containing a superfluity of solid matter, either primarily or owing to a change in the urine itself, which acts as a preventative to their solution, does not always give rise to the development of stone, and also as it is known that sediment may exist in the urine without their formation. This is explained by the fact that some organic matter is necessary to their development, and the absence of which may act as a preventative to their formation.

This organic factor must be sought in some diathesis or constitutional anomaly, the result of which is the excessive production of some of the substances that enter into lithic formation, as the uric acid diathesis, etc.

The bladder changes consecutive to stone formation are all more or less mechanical in their nature. As owing to their weight they may cause sacculated conditions, or when possessing a rough surface give rise to considerable irritation and injury to the mucous membrane, and which may also cause reflex contractions of the bladder, which leads to hypertrophy. When small they may become lodged in a ureter, giving rise to the development of hydro-nephrosis.

Lastly, they may set up inflammatory changes, either directly through the irritation they produce or indirectly by causing more or less retention of urine, which gives rise to fermentative processes. When the former, the inflammation may take on a fibrous character, resulting in the complete encysting of the stone or in it becoming firmly attached to the bladder wall.

Inflammatory changes frequently precede the actual stone formation, as not uncommonly they are set up by the presence of a small kidney stone, which then forms the nucleus for further development, as has been previously intimated. Calculi of large size from their presence may also seriously interfere with the functions of neighboring organs, as, for instance, by causing pressure on the rectum or uterus. Through ulcerative processes, which at times occur, subsequent to encysted calculi and those found in diverticulæ, they may leave the bladder, giving rise to urinary infiltration, abscess formation, and fistulæ.

DIPHTHERIA—ITS PREVENTION.

BY WM. A. SEIBERT, M.D., EASTON, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania,
September 19, 1893.)

HOMŒOPATHY, Listerism and Bacteriology have each performed invaluable *indirect* services to humanity that present a similarity, though they themselves bear no further resemblance. Homœopathy thoroughly revolutionized the so-called "regular" medical abuses into much milder therapeutics at least, besides in itself being the most important therapeutic discovery of the age. Listerism did a similar service for surgery by taboing uncleanly and careless work, even if it, *per se*, possesses no merit. Bacteriology has made its similar impression on preventive medicine by encouraging stricter methods in general hygiene and enforcing isolation of the infected, though itself probably overrated.

It will be noted that the measures that had been adopted as most efficient in the prevention of diphtheria before the field of bacteriology was opened, turn out to be also eminently uncongenial to the existence and multiplication of the diphtheria bacilli. In the discovery and description of the various bacilli and their ptomaines

Klebs and Löffler simply reduced to scientific study what had been empirical in the prevention of diphtheria. They may not be the sole cause of the disease; they may be simply unhygienic accompaniments, but they seem uniformly present, and the elimination of so constant a factor becomes an extremely desirable object. Their discovery has probably not enhanced our knowledge of the medical treatment of diphtheria, but it has most emphatically drawn attention to its preventive treatment.

Usually, many things can be done by physicians, health boards and communities to lessen the probabilities of persons contracting the dread disease. It is possible in the scope of such a paper only briefly to call attention to a few dominant facts that are to be pre-eminently considered in the prevention of diphtheria.

Before the disease appears, after it does make its appearance, after convalescence or death—all the time—nothing goes so far towards prevention as good pure air and sunlight and plenty of both, at the same time mindful that draughts are deadly. Bedrooms should contain fewer occupants to the cubic feet of contents, and they should be more thoroughly ventilated night and day, winter and summer. Everything that might vitiate the air in the least should be banished from the room, especially that article so frequently allowed to be even without cover under beds. There should be fewer curtains and hangings to interfere with abundant rays of sunlight and free circulation of air, besides furnishing inviting lodgings for impurities, including germs. The air will also eddy and form stagnant pools back of the hangings, in which impure air may become more impure, because of the retention of organic and decaying odors that will unavoidably find their way upward, particularly from the kitchen. Sewer air—or sewer gas, as it is often improperly called—is another source of contaminating our air, and, being such an extraordinary vehicle for and breeder of poisonous germs, it must be rigorously excluded from our houses. It is also hardly open to question that the continual breathing of air polluted by emanations from sewers often produces more or less serious derangements of health predisposing to any disease. Soil air is still another cause of vitiating the air we breathe, and has probably had a most active interest in the epidemic that has been visited upon Easton during the past two years. For several years there has been one incessant turning up of our old streets, many of which have been almost hermetically sealed by overlying macadam. At first it was necessitated by the establishment of a system of sewerage over the greater part of town requir-

ing digging to great depths in such a hilly region; then followed equally, if not still more, extensive throwing up and piling up of ground all over the town for the purpose of establishing an elaborate system of electric railroading; and then followed, and is still being continued, another digging up of the streets and hauling through the town of sufficient surface to permit of modern street-paving. We are unable to assert with confidence that this alone has been the cause of our epidemic; for we are having other notable sources of air contamination at Easton, and it may be that we have simply suffered the effects of the diphtheria wave that is supposed to repeat itself every six or seven years. Nevertheless, soil air is contaminated air, and this undoubtedly does make the certainty of the contagion greater. Everything impure in the cellars, yards and neighborhoods that might render our air impure should be removed, remembering that one decaying rat or one pail of swill refuse pollutes more air than a massive and unsightly pile of coal ashes. Privies and cesspools need especial attention, or they must render impure many cubic feet of air daily, much of which will get into our houses.

Pure atmospheric air and sunlight are probably nature's disinfectants, and are the best now known for universal use; and as long as there is no epidemic they will probably answer every purpose in the prevention of diphtheria. In time of epidemic the free use of the best deodorant and best artificial disinfectants known are not gainsaid, but we do, incidentally, disapprove of strong-smelling chemicals that are supposed to disinfect. But pure air, sunlight, and all the best disinfectants known avail nothing if the food or drink be infected, or if we be otherwise exposed to the contagion. Water, that can be very easily contaminated by the soil, air, and milk form two very potent vehicles for carrying the bacilli. Direct contagion often results in school and from books, especially where the free school-book system exists, and from infected chickens, cats, canary birds, and other pets. After the bacillus makes its presence in a home known, then the one predominant feature in the preventive treatment of the disease is isolation—prompt, complete, and continuous isolation of all infected persons and things. All but the sick and those waiting upon them should at once be removed from the house, and we do believe thorough quarantine should be productive of the best results. This, however, is not feasible unless established by law and carried out by paid officers. The anxiety to prevent at this stage becomes so intense that everybody is apt to become quite uncharitable and even cruelly severe in trying to enforce quarantine,

a thing impracticable, though possible, in cities. Health boards will do things that keep a community in a constant state of terror. They will publish in the dailies a report of the new cases and display a flag, or, as at Easton, a large blue card with the word "diphtheria" in large letters upon it at the most conspicuous place on the front of the house. Almost every child, and very many adults, develop a "holy horror" of the disease. Fear may have something to do with susceptibility, but it has an undoubted influence upon the prognosis in victims of the scourge. The question arises whether newspaper reports in detail could be omitted, and whether it would not be possible to serve an equally sufficient warning to those about to enter the infected house. And the physician himself will do what seems sufficient to alter the prognosis in many a case. Take, for example, the recommendation in Burnett's recent elaborate treatise upon *Disease of the Ear, Nose, and Throat*: "If diphtheria be suspected the physician should, before entering the sick-room, remove his coat and vest and cover his body, neck, and extremities with a sheet fastened around the neck." Theory and practice may be handmaids, but they are certainly at times quite uncongenial. May the purpose of this sentiment not be misconstrued, for the good of the community should be uppermost, and their safety is not bartered if these prophylactic measures be reasonably modified. It is not the object of this paper to excuse careless physicians. They should not expose themselves unnecessarily; their visits should be brief, and on leaving the house it were best to wash face, head, beard, and hands in an antiseptic lotion, as one of corrosive sublimate.

After death or recovery, the predominant fact for consideration, in order to prevent the spread of diphtheria, is thorough disinfection and fumigation. These methods include scraping of walls, re-papering them, and re-painting, and free ventilation all the time. Most careful attention should be given to the disinfection of the patient himself before re-admitting to school, since many cases originate from exposure in public schools. School boards and superintendents, as well as health boards, are the servants of the people, and should act always for the best interests of the people. It is not sufficient, on the contrary an absurdity, to expect physicians to give certificates guaranteeing safety in re-admitting school children. Physicians cannot, in the light of present knowledge, conscientiously give a certificate, such as school authorities generally exact, without the expenditure of much time and possibly repeated bacteriological examinations.

School authorities find it very convenient to shift duties upon others when they should be expected to co-operate with the health board, and should require of the physician in this matter only a certificate that their laws have been complied with. Stamping out a diphtheria epidemic is a matter of the gravest import, and needs general pre-meditated co-operation.

In accordance with the latest and most exact experiments the following disinfecting agents have been preferred as the best of all the hundreds recommended by the many authorities consulted: *Boiling water* or *live steam* (100 C.) for half an hour is the very best for all kinds of material not destroyed by moisture. *Dry heat* (130° C. = 266° F.) for two hours for articles which would be injured by moisture. *Chloride of lime* very freely used for all discharges, including vomited matters and sputa. This should contain at least 25 per cent. of available chlorine, and should be dissolved six (6) ounces in a gallon of water. *Bichloride of mercury*, 1 to 500, after adding five grains sodium chloride for every grain corrosive sublimate, for washing surfaces and for soiled linen, etc. This should be weakened to be 1 to 2000 or 3000 for repeated application to the surface of the body. *Milk of lime* made from freshly burnt lime by mixing the hydrate with water in the proportion of 1 part to 8 by weight. This is the best agent for disinfecting privies by adding 5 parts of it to every 100 parts of the contents of the vault, and adding 10 parts for every 100 parts of daily increment. This is also very valuable as an application to walls of plaster and wood. The *dry fresh quicklime* is also one of the best absorbents of moisture from the atmosphere known, so that pieces of it placed about the house and cellars to air-slake will not only dry the air but will destroy poisons contained in the moisture where they generally do exist. *Platt's Chlorides*, *bromo-chloralum* and the like are the best kind of deodorants, but they have been proved disinfectants of no worth, and should not take the place of the better disinfectants. Finally *sulphur* for "fumigation." We should remember that the anhydrous sulphur dioxide has very little germicidal power, and that therefore it is necessary to moisten the objects and surfaces, or to introduce steam into the closed apartment with the sulphur fumes, so that the very valuable disinfecting agent, sulphurous acid, is formed. Three pounds should be used in each 1000 cubic feet.

Such, then, are the leading measures I should recommend as most likely to prevent the propagation of diphtheria. Recapitulating the predominant facts:

1. In non-epidemic periods plenty of *pure air and sunlight* in houses, and bed-rooms in particular.

2. In epidemics, plenty of pure air and sunlight re-enforced by well selected *disinfectants*.

3. At all periods *avoiding exposure* to infected persons and things.

4. When the disease makes its appearance in a house then *isolation*, superadded to the continuous and vigilant disinfection of the patient and his surroundings.

5. After death or recovery, *fumigation*, and thorough disinfection and house cleaning.

All through this process to prevent diphtheria is observed the crusade against the bacillus. On the one hand the pure air and sunlight to prevent his existence, and on the other hand disinfection and fumigation to kill him. It is easy, however, to be so engrossed with these absorbing and important phases of prophylaxis to such an extent that we mistake the cause or accompaniment of the disease for the disease itself, and thus forget the personal element with its predisposition and the value of prophylactic medicine. The homœopathic remedy most frequently indicated in the cases then extant, or *apis mellifica* in particular, administered in time of epidemic should be added to the above means of prophylaxis and epidemics of diphtheria would become appreciably diminished in frequency and severity.

THE TECHNIQUE OF WOUND TREATMENT.

BY H. L. NORTROP, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania,
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THE late Sir William Fergusson, commencing an address on modern surgery, said, "The glory of surgery is precision." And, he might well have added, the secret of surgical precision lies in aseptic and antiseptic accuracy—accuracy in Listerian details (for Lister is as firm a believer in asepsis as he is in antisepsis; he contends that the former is inadequate without the latter).

What is the highest compliment that can be paid to a surgeon? That he is a rapid operator, and can handle the scalpel with a flourish? No; nor is it that he even commands anatomical accuracy. It is that he possesses good judgment, and no small part of this judgment lies in dealing with and carrying out the details of his

work. To a surgeon of good judgment good results are insured, and the laity as well as the profession quickly decide who is the skilled and successful surgeon by the results which this or that operator obtains.

The watchword of modern surgery is "The wound," and the countersign to success in wound treatment, "Antisepsis." Everything in operative work is subservient to the wound; how it is guarded and cared for; what devotion—almost reverence—is paid to it. Before the operation, the surgeon may ask himself where and how the wound shall be made; what shall be its length and shape? But that which will concern him more than these, will be the question, what can I do to prevent that surgical horror, pus.

Every one who has performed an operation, or treated a wound, and obtained primary union, has experienced a feeling of satisfaction with the result; and there surely is cause for self-congratulation when, in these streptococcic days, one secures union *per primam intentionem*. If septic infection takes place, and the sutures must be removed and the wound permitted to heal *per secundam intentionem*, one feels humiliated; there has been a failure to a certain degree. More than the gratification felt upon good, primary wound-healing, is the importance, the necessity, of securing it. In herniotomy, how necessary it is to obtain a firm, solid cicatrix by primary union, that there may be the less likelihood of a relapse; in all plastic and joint operations, in abdominal work, when the cranial cavity is penetrated, how much of life and future health depends upon the freedom from complications during the after-treatment?

But, this is "the old, old story." Without a moment's hesitation, we decide that anæsthesia is the greatest surgical innovation of the nineteenth century; upon antisepsis we confer second honors. This is an age of surgical marvels and operative triumphs, made possible by the anæsthetic and the antiseptic. How foreign to the times it sounds to read the following, which appeared recently in a New York journal:

"It is a lamentable fact, however, that with one, or possibly two, exceptions, the surgeons of Edinburgh utterly fail to appreciate the advantages to be gained by the application of the modern aseptic and antiseptic methods of wound-treatment now so generally practiced by surgeons throughout the civilized world; or, if they appreciate the advantages, fail to give their patients the benefit of them. It is true, that they employ antiseptic solutions for cleansing the wounds, and occasionally a part is scrubbed before operation. The

surgeon usually washes his hands, and as frequently wipes them on any towel that happens to be near. The assistants rarely take this precaution, and the nurses never (in public)."

Says the writer: "I witnessed a shoulder-joint amputation before the class, by Edinburgh's most distinguished professor of clinical surgery. Neither the surgeon nor any of his assistants wore anything other than their ordinary garments. The hands may have been disinfected, before the operation, but certainly nothing further was done during this or the following operation to overcome the contamination necessarily incident to the free handling of soiled towels, wooden chairs, tables, instrument-cases, woollen blankets, and various other articles about the amphitheatre, and contained in the pockets of the operator and his assistants.

"In the midst of the operation, the surgeon takes a spectacle-case from his coat-pocket, removes his glasses, places them in position, and resumes his work without even immersing his fingers in any of the antiseptic solutions which are everywhere present. The drainage-tube which is employed is passed through at least two pairs of septic fingers, and has been in contact with the hair and coat-collar of the operator.

"On one occasion, however, it was encouraging to see the operator and his house-surgeon in clean linen gowns, with sleeves rolled up, and with apparently clean hands. The operation was for the removal of a foreign body from the knee-joint, and as the patient's leg had been thoroughly scrubbed and was surrounded by towels wet in some antiseptic solution, it seemed that the operation was to be conducted as such operations are in our own (American) hospitals by our own careful surgeons. About the middle of the operation, however, the assistant whose duty it was to look after the instruments and prepare the ligatures and sutures, came into the amphitheatre with a crowd of students from above, descended the stairs, jumped over the rail into the arena, and immediately began to perform his duties without washing his hands or even dipping them into a solution which was easily within reach. The surgeon called for a gut suture to unite the capsule of the joint before closing the wound. The young man threaded a needle, and not at once finding a pair of scissors to cut the gut, plunged his hands into a pocket, withdrew a pair of scissors, divided the suture, and then, as if to remove any possibility of its being clean, drew its whole length between his more than septic thumb and forefinger. That suture and many others prepared in the same manner were used, and that without a word of

censure from the surgeon, who was obliged to witness all while he waited for the needle. The dressing which was placed next the wound was handled by two nurses, neither of whom had taken the slightest precaution to disinfect their hands."

The author believes this to be a fair example of most of the surgery to be seen at the Edinburgh Infirmary. He does not tell us of the zigzag temperature, the pain, the pus formation, possibly pyæmic, a secondary operation, an amputation, followed by—perhaps death. But we can rightfully assume that some, at least, of this list of calamities were enacted during the succeeding weeks. Such surgery and such asepsis (or rather the lack of it) should not be countenanced at the present day even in private practice; and much less in the convenient, well-equipped hospital operating-room. Here, if nowhere else, are we to obey and carry out, as perfectly as we can, the principles taught by Lister, and dictated by experience and judgment.

To lay before you one method of practicing antiseptic surgery, let me describe to you the manner in which wounds are cared for during the service of Dr. Wm. B. Van Lennep and myself in the Hahnemann Hospital of Philadelphia.

In the first place, upon the day previous to that appointed for the operation, the patient is given a tub-bath, and the part to be operated and its neighborhood shaved (if necessary), scrubbed with *sapo viridis*, and then enveloped in a towel saturated with a solution of bichloride of mercury, 1 to 2000. The application of the wet towel is repeated upon the following morning, shortly before the operation. If the operation is to be an intra-abdominal one, a *sapo-viridis* poultice is placed in contact with the abdominal walls for the 24 hours before the operation; and then, finally, the poulticed surface is scrubbed and protected by the bichloride towel. The patient is anæsthetized and wheeled into the operating arena with these surface preparations previously made. The exceptions to this are very few.

Within the arena may be found, besides the patient and official anæsthetist, the following: the operator; the first, second, and third assistants; the "clean" (*surgically* clean) and "dirty" nurses, and the clinical nurse. Each one has his or her special duty to perform, and all are governed by rules, which, printed in large type, hang on the wall of the scrubbing-room. I wish to quote these rules, verbatim:

"The assistants shall be: First, junior attending surgeon of the

Hospital, or clinical chief. Second, the house surgeon or physician. Third, one appointed by the clinician or operator. Fourth, one of the nurses, to be known as the "clean" nurse. Fifth, one of the nurses, to be known as the "dirty" nurse.

"N. B.—Other assistants may be selected from the Dispensary or Training School. Assistants shall hold their positions in rotation, as much as possible. In the absence of an assistant, the next in rank takes his place.

"*Duties of First Assistant.*—1. Have general supervision of clinic under chief, and appoint and regulate time of service of second and third assistants. 2. Direct third assistant and clinical nurse in placing patient, pads, towels, etc. 3. Direct third assistant in the preparation of the parts for operation, and complete or direct the completion of the dressings under the chief. 4. Cleanse and disinfect hands and forearms, keep them wet and surgically clean, and touch nothing that is not surgically clean. 5. Second and anticipate wants of chief, assist in operative work, and direct the work of all assistants and nurses under chief.

"*Duties of Second Assistant.*—1. Cleanse and disinfect the hands and forearms, keep them wet and surgically clean, and touch nothing that is not surgically clean. 2. Have care of instruments, needles and suture materials during the operation; see that they are kept in proper order, wiped and immersed when returned from use, and allow no hands but his, the operators and the first assistants, to touch them.

"*Duties of Third Assistant.*—1. Assist in placing the patient in position and prepare the part for operation. 2. Have care of irrigation, pads and mackintosh sheets, protecting towels, etc., and see that they are kept in order. 3. Hold the parts and patient in position, and see that the surrounding parts and clothing are protected. 4. Assist in the application of the dressings. 5. Accompany orderly to the ward, and assist in placing patient in bed, and remain until the ward-nurse takes charge of the patient.

"*Duties of Fourth Assistant.*—1. Cleanse and disinfect hands and forearms, keep them wet and surgically clean, and touch nothing that is not surgically clean. 2. See that all dressings and dressing material are ready in the order in which they will be needed. 3. Cleanse and hand sponges and tampons, squeezing them dry unless otherwise ordered; place wet towels in position, and change them when necessary, etc. 4. At termination of the operation, present dressing.

*“Duties of Ward Nurse, or Fifth Assistant.—*1. Prepare patient for operation according to orders. 2. Accompany patient to the anæsthetizing room and remain there during the administration of the anæsthetic. 3. Accompany patient from anæsthetizing room to operating arena, carrying a Kelly pad, two mackintosh sheets and pail. 4. Place these in position, as ordered. 5. Render assistance as directed by operator, the other assistants, anæsthetist, or clinical nurse. 6. Remove towels, soiled dressings, mackintosh sheets, etc., to side room at close of operation. 7. Follow patient to ward and take charge.

*“Duties of Clinical Nurse.—*1. See that the operating rooms are properly heated and ventilated before and during an operation, and that the doors are kept closed. 2. Care for and arrange proper instruments for each operation before the time for operation, subject to the instructions of the chief and first assistant. 3. Place table, instruments, dressings, etc., in proper position. 4. Supply water for irrigators and basins. 5. Assist in moving and placing patient. 6. See that the room is in order and cleared between cases. 7. Not to go out of operating room unless absolutely necessary. 8. To save all specimens, tumors, etc., present them to the chief at the close of the operation, and, if so ordered, take them to the proper place and party for examination and preservation. 9. Not to touch anything surgically clean except with surgically clean hands. 10. Bathe frequently, wear clean clothing, and keep hands and forearms clean.”

The hands and forearms of all who are surgically clean are scrubbed thoroughly before the operation with sterilized brushes and *sapo viridis*, immersed in a solution of permanganate of potash (six ounces of crystals to the gallon of water), then in a solution of oxalic acid (twelve ounces to the gallon) until the permanganate stain is entirely removed, and are finally dipped into bichloride of mercury solution, 1 to 1000. Those who are surgically clean must remain strictly so from the beginning of an operation, or dressing, until the final part of the dressing is applied. At no time can a “clean” assistant or nurse touch a blanket, Kelly pad, jar of gauze, powder box, or even his or her own, or another’s, operating gown, without immediately immersing the hands in the deep basins containing the bichloride solution.

If an instrument is dropped upon anything not aseptic it is boiled before it is used again. If something contained in a jar or basin with a cover to it is wanted, a “dirty” assistant must raise the cover, when the article may be removed by one surgically clean.

Just before the incision is made or the operation begun, the third assistant vigorously scrubs the proposed seat of the wound with a freshly sterilized brush dipped in a solution of carbolic acid, 1 to 20. This is in accordance with Lister's earlier views, and recently reiterated. During the operation the wound is irrigated with bichloride of mercury solution, 1 to 2000, or with distilled water, as frequently and as freely as is deemed necessary. All solutions are made with distilled water. The nozzle of the hard-rubber irrigator is removed after each operation and dipped in boiling water.

Catgut sutures and ligatures are prepared according to the juniper oil process; silk sutures and silkworm gut are kept in bichloride of mercury alcohol, 1 to 2000.

All instruments, including needles, are boiled in a solution of bicarbonate of soda immediately before each operation, and are kept in a similar solution during the operation.

The neighborhood of the wound is carefully protected by pieces of mackintosh covered with towels wrung out of hot bichloride solution. These towels are changed every few minutes or oftener, if necessary.

Wounds that can be closed are united by the buried or subcuticular suture of iron-dyed silk, size 0₁ (conjunctival), and sometimes of catgut, medium size. If there is tension upon the flaps of the wound the ordinary interrupted suture of heavier silk is made use of wherever necessary.

The subcuticular suture has many advantages: In the first place there are only one or two needle-holes (*i.e.*, if silk is used, and none if the suture is of catgut) perforating the skin and offering points for infection and the development of stitch abscesses. The suture, which is entirely hidden save the anchoring knots near each end of the wound, is thus removed from the liability of surface contamination. After union has taken place the cicatrix appears as a fine, even, linear scar with no transverse stitch-marks, often as noticeable and as hideous as the scar from the operation wound. For this last reason the suture in question is especially advised in wounds where the cicatrix should, for cosmetic effect, be as nearly invisible as possible.

In applying this suture, a full-curved needle is used and is introduced near one angle of the wound and brought out within the wound, at the angle. It is now inserted into first one flap and then the other, successively, quite close to the surface, care being taken that each puncture includes the deeper part of the cutis vera, but not

its entire thickness. The needle should emerge from the true skin at its cut border. When the end of the wound is reached the suture may be terminated in one of three different ways: If no tension upon the flaps exists the end may be cut off close to the wound and allowed to retract out of sight; it may be brought out through the skin an inch or so away from the angle of the wound and the end left long, though not anchored; or, an anchoring knot may be placed near the wound angle and the final stitch tied to this. After union has taken place the silk is easily removed by liberating the ends and simply drawing out the thread from beneath the surface. If catgut be used, both ends may be buried, the final anchoring knot being placed within the wound, thus exposing no suture material whatever. Hagedorn needles are used exclusively.

Drainage is almost never provided for. During the past six months the rubber drain has been used in two cases of psoas abscess; the capillary gauze drain has been used only in cases of trephining.

The same care in aseptic details attends the preparation and application of the dressing. Whenever a drying powder is to be dusted over a wound, the powder-box is handed to the chief or first assistant wrapped in a piece of sublimated gauze. No "clean" hands touch the box itself. The routine dressing consists of a few layers of iodoform gauze (10 per cent.) wet, at the time of its application, with bichloride solution; outside of this is placed sterilized gauze direct from the sterilizer, and also dipped in bichloride solution; to these, the absorbent parts of the dressing, sterilized sheet or raw cotton is applied. This is the impervious part of the dressing. The whole is bandaged with sterilized gauze or muslin bandages.

Each member of the operating corps knows his or her duty well, and is so trained that the work moves along smoothly and is performed without confusion. So perfectly do the "clean" and "dirty" assistants understand their rôles that a "dirty" nurse may be seen accompanying a "clean" one to some part of the operating-room, opening doors, removing lids of jars, boxes, etc., for her, while the "clean" nurse touches nothing that is not surgically clean, and thus preserves her hands in a state of surgical cleanliness.

Moreover, it is considered the duty of any one who observes a break in the strict aseptic regime to bring the guilty one, even the chief, to task publicly and at the time of the error.

In dressing wounds the "dirty" assistant adjusts the pad, etc., and removes the dressing down to the deep layers of gauze. Then, "clean" hands only complete the work. Dressings are renewed

when there are indications for an inspection of the wound-rise of temperature, pain, appearance of discharge, etc. The majority of operated cases remain from six to eight days before a second dressing is applied.

The results of this military-like precision in aseptic and antiseptic details are most satisfactory, and commended highly. The same, or a similar method, can be carried out in private practice, though, of course, not so elaborately as in the hospital. Let us, then, *insist* upon precision in the practice of antisepsis that we may share in the "glory of surgery."

A CONTRIBUTION TO THE STUDY OF PARANOIA.

BY J. T. GREENLEAF, M.D., OWEGO, N. Y.

(Read before the Homœopathic Medical Society of the State of Pennsylvania.)

THE prevailing idea that the insane are sick and not devilish, are human and not demons, and that they should be treated with love, gentleness and care, and not with hatred and abuse, with chains and stripes, with neglect and imprisonment, is well known to be still in its infancy. Those men whom we honor with the title of Alienist, are the product of the rapid growth of this idea, and very many new words and phrases are noted in the literature of neurology in these "fin de siècle" days. These words are not names for new diseases, nor new names for old ones, but are the result of closer study on the part of alienists, and of an effort to arrange and employ a more accurate nomenclature for the definite trains of symptoms or groups of phenomena as they arise in the history of cases of mental disease. Among these recent words and modern classifications is the term "paranoia," to the study of which this brief paper is a contribution.

Paranoia is a form of insanity that presents many fixed phenomena and characteristics. First: It is generally developed in those who are permanently possessed of an irritable condition of the nerve-centres, especially those centres which preside over the higher or psychical spheres. The symptoms and conditions which mark this (so called) neuro-psychopathic constitution are readily discoverable, and are as follows: the sleep is irregular; very slight over-exertion often inhibits sleep; any strong emotion, like fear, transient anger

or momentary mortification or chagrin experienced during the day will keep sleep from the eyes of these human sensitive plants on the succeeding night—hence these patients are the ones who are obliged to have a light in their bed-chamber during the night, are afraid in the dark, scream at sudden noises, and are indulged by their relatives in nearly everything they may desire, to avoid nervous outbreaks. We also find them easily affected by heat and cold; they shiver with a chill or are burned up with a fever at every change of temperature in their locality. Any slight disturbance of their ordinary rule of physical life, coryza, indigestion, slight bronchitis, unimportant enteric catarrh, sends them to bed, and delirium and sometimes light convulsions ensue. Headache, in its protean forms, is an ever-present element in such lives. In these times of almost universal use of alcohol, we find both the male and female subjects of this peculiar dyscrasia fond of this potent hydrocarbon, and especially susceptible to its power. Their sexuality may be either diminished or exaggerated, according to their home influences, and especially according as they have or have not any orificial defects or deformities, and according to their acquirement and practice of the habit of masturbation. They are self-conscious to a painful degree. Their emotions are strong, and take entire possession of them for the time, but they are fickle and wayward in the extreme, and, as a result of this, are always lacking in application, determination and endurance.

It is easy to find in the foregoing picture the petted and pampered darling of a father whose own success in life has led him to more or less moral obliquity, or the wayward son to whom his mother has imparted her own neurotic temperament in the outstart, and whom the pride and foolish indulgence of that same maternal worshipper has furnished with many a surreptitious dollar for the further excitement of a nervous system already weakened and impoverished by her sybaritic training in the days of his early youth. In short, the homœopathic school of this great and prosperous Keystone State numbers thousands of these cases among its best families, and every prudent man among its practitioners is trembling to-day for fear some terrible fate is awaiting these dear, petulant, vivacious, unreasonable, well-paying, troublesome, exacting patients of theirs.

Second. The paranoiac generally has a definitely-fixed delusion. The form of delusion which is found in the class is not at all fixed, but the delusion of each individual case is generally well marked

and permanent. While it is impossible to detail the different delusions which are likely to control these unfortunate children of a hot-house growth in such a contribution as this, yet it is safe to say that an overweening idea of importance, in the form of an exalted consciousness of his own value to the family, the town, the State, the church, or the world, is quite likely to be the basal thought of the logical progression of his reasoning, though the exact opposite is not infrequent. His own self-consciousness may simply be aggravated into the idea that everybody is watching him, and that every act of others has a reference to him and to him alone.

Third. While the paranoiac is never free from the influence of the underlying delusion, he may be, and generally is, able so to control it and himself for days and even weeks at a time, that he acts as if he were sane and uninfluenced by any erroneous ideas. At these times any ordinary observer would fail to discover the slightest variation from a correct line of life or thought unless he should casually say or do something that would probe down to the special delusion, and thus reveal its existence.

Fourth. Under old-school treatment these cases are considered incurable, hence the books which are written from that standpoint are agreed on this point. Within the last few years some cases have recovered wholly or in part under the influence of hygienic surroundings and devices and the properly selected homœopathic remedy for the given case. Cases of paranoia make so much trouble at home and so mortify their fond relatives that they have to be placed in a retreat or sanatorium, and so all reference to home-treatment is omitted in this paper. Prevention is often in the reach of the trusted physician of those who possess this constitution, and it is his duty to examine the genitalia of such people and operate on all the deformities of this region of the body. The prepuce should be freed from all adhesions, and if very redundant, circumcision should be performed; stricture of the urethra should be dilated, and any stenosis of the anus should be removed. If the hood of the clitoris is found to be adhered or too tight, that little erectile organ should be freed from all irritating surroundings; in some cases the hood will be found to be very redundant, and should then be excised, redundant labiæ minoræ should be removed, spasm of the ostium vaginæ should be overcome by proper dilatation and the anus operated in like manner if necessary; all uterine dislocation and inflammation should be removed by remedies or local care as the case may seem to require. Those who masturbate are most likely to seem to possess a diminished

sexual instinct, but they usually begin the practice of this habit to satisfy a morbid sexuality. This combination is one to be dreaded, but when all orificial deformities have been removed much may be gained by the wearing of a collar of firm muslin or soft leather to which straps of the same material may be attached so as to preclude the approximation of the hands to the genitalia. This is needed at night to avoid the involuntary return to the old habit in those moments of semi-consciousness which occur when the patient is falling asleep, or in the early morning when only half-awake, and should be discontinued as soon as the patient finds that he can be trusted with free hands at all times. Among the precautions which wisdom would suggest to any thoughtful physician as a possible means of averting a nervous catastrophe or psychic crash are those gentle, fatherly, conversational lectures which every good disciple of Hahnemann knows so well how to give, comprising a truthful statement of the probability of future trouble and tempered with such care as not to alarm the patient, but to achieve a change in the pernicious manner of life and thought. It is extremely helpful to arrange for some light employment, fictitious if necessary, which may occupy the mind and time of these patients and serve to divert them from thinking of themselves and their incipient delusions or false views of life. In short, every mental, moral, physical or hygienic means which promises anything at all should be joined to the great panacea of the similimum in safe doses and continued for a long time.

Although the patient who is afflicted with paranoia generally passes on from the occasional harboring of a delusion or an exalted idea of his own importance to that state in which he can no longer be trusted to perform his domestic duties, assume his business relations nor enjoy the pleasures of social life, it should not be forgotten that in some cases this peculiar form of insanity develops suddenly from nervous shock or from traumatism; as a sequela of typhoid fever or other profound disease. Homicide is hardly ever attempted, though violent and unprovoked assaults are frequent. Suicide is only to be dreaded in the cases of the depressed type. Whether the prolonged and faithful labors of the physician have failed either to abort or to retard the onset of the disease, or he is only called to advise when the symptoms break out suddenly, there is but one course to pursue when the malady is fully established, and that is to send the patient to a retreat.

When one shall have been selected that promises the best and most intelligent care and offers a price which is satisfactory, it is always

best to explain to the patient his mental and bodily condition as fully as possible, concealing nothing but the prognosis. And these cases pass so many days in which they seem entirely sane and are apparently able to attend to their own affairs, it seems to be an act of simple humanity to choose a retreat where the surroundings are as homelike as possible, and where contact with those who are more violent can be entirely avoided.

The scope of this paper forbids the prolonged discussion of remote causes, of special symptoms, of peculiar delusions, and the citing of individual cases, but it is hoped that enough has been included to assist in the proper and intelligent care of the ordinary case of paranoia.

SIMPLE NEURITIS.

BY JOSEPH C. GUERNSEY, M.D., PHILADELPHIA.

(Read before the Homoeopathic Medical Society of the State of Pennsylvania,
September, 1893.)

It is a mistake for a physician to pay over attention to his *materia medica* at the expense of his pathology and diagnosis.

We all agree with Hahnemann that "the first and *sole* duty of the physician is to restore health to the sick." But health cannot always be restored to the sick by medicine alone; indeed, in the majority of cases a cure predicates the knowledge and use of hygiene and dietetics, pathology and diagnosis, proper nursing and proper local treatment (non-medicinal) such as massage, application of heat or cold to the affected part, etc., all the foregoing, *plus materia medica*, are more or less needful in every case of illness whether acute or chronic. It is no joke for a patient suffering with pneumonia to be assured by his physician that he has "only a heavy cold, and can go out to his business if he is carefully wrapped up." We all know how such a case would likely end. Nor will it do to simply prescribe the *similimum* for a case of chronic diarrhoea without carefully attending to the patient's diet, nor to prescribe for continual headache without particularly inquiring into the patient's hygienic surroundings; as to whether he works in a close room unpurified with fresh air, and whether he takes enough exercise; also, whether he does not need eye-glasses. In fever cases the most accurate prescribing will be of small avail unless accompanied by judicious nursing. In cases of

uterine hæmorrhage, whether at change of life or "too profuse" monthly menstruation, the woman must be kept in bed until better. And so instances might be multiplied.

One of the most important requisites to a cure, after *materia medica*, is diagnosis. Especially is this so in our present subject for discussion.

Neuritis.*—Many a case of which is diagnosed and treated as rheumatism or neuralgia. This is an unfortunate mistake, as neuritis is always a serious affection to deal with, and its cure requires an early and correct diagnosis. A neuralgia may be fought, provided one is willing to endure the pain. Neuritis, on the contrary, must be yielded to if a cure is hoped for.

Ætiology.—Neuritis is inflammation of a nerve or nerves, usually the outer sheath of the nerve; it may involve the connective tissue between the bundles of nerve-fibres, or even the nerve-fibres themselves. Usually, only one nerve-trunk is primarily affected, but sometimes many nerves, "primary multiple neuritis," suffer at the same time. The tendency of neuritis, beginning as acute, is to subside into a chronic stage, and its symptoms may persist for a long time—for months and even years. Any injury to a nerve, no matter how slight; whether caused by contusion, incision, puncture or stretching, may be followed by sufficient traumatic inflammation to cause a severe attack of neuritis. I know of a neuritis caused by a gentleman riding horseback for several hours with one stirrup so long that his foot barely touched it, thus stretching the nerves of his leg terribly. Mechanical injuries may cause neuritis, as a blow on a nerve-trunk, or a sprain from violent efforts to raise heavy weights.

Nerves that pass by joints may be injured by dislocations, or even by reducing the same; while in fractures the nerves may be directly injured, or may be compressed by the callus that is formed. Any external pressure on a nerve may produce inflammation, as a shoulder-strap or suspender. I believe that many a base-ball pitcher suffers from an unrecognized simple neuritis. It may also be caused by adjacent inflammation; and the nerves near suppurating joints may be involved; or even those that pass by a joint that is affected by rheumatism. Exposure to cold is a common cause, and it is then often called "rheumatic."

Neuritis is also caused by certain diseases, such as gout, syphilis

* See *Diseases of the Nervous System*, by W. R. Gowers, M.D.

(chiefly affecting the cranial nerves), and cancer, occurring in the latter instance in the neighborhood of a cancerous growth. In cancer, nerves adjacent to the new growth may present simple neuritis, or may be infiltrated by a growth of cancerous elements spreading to the nerve by direct extension. Such acute diseases as smallpox, typhoid fever, diphtheria, the acute exanthemata, and others, may cause simple neuritis. Herpes zoster is a result of neuritic processes.

Pathological Anatomy.—In acute inflammation, the affected part of the nerve is red and swollen; the redness and swelling often being visible on the surface—the swelling due to œdema, or to a sero-fibrinous exudation. The foci of inflammation are chiefly situated at places where the nerve turns around a bone, or emerges from canals or fasciæ, or divides. The extent to which the nerve fibres suffer varies. They usually present little change when the inflammation is limited to the sheath unless the nerve lies in a bony canal or in rigid fibrous tissue, within which the sheath cannot expand; its swelling then exerts pressure on the fibres.

Symptoms.—The chief systems are local, the most prominent being the pain of the inflamed part of the nerve, often including the part to which it is distributed. Thus the whole limb may be involved, and in severe cases the pain is most intense and agonizing; burning, boring, or as though the limb were being forcibly pulled off, usually worse at night; is increased by movement, by movements or positions that involve tension or pressure on the nerve; by whatever causes passive congestion of the limb, and by everything that excites the circulation. This pain may radiate into distant parts, and even felt in the corresponding region of the opposite limb. There is great sensitiveness of the whole of the affected region, and even the bone may be tender, so that at first attention may not be directed to the nerve; but, when this is pressed, great pain results. If the nerve is accessible to direct examination, it may be felt to be distinctly swollen at the affected part, and in some cases a *red line* is observed in the skin over the course of the nerve. The nerve is always *extremely sensitive* to pressure or pinching. Spontaneous sensation may be felt in the region supplied by the nerve, tingling, etc. After a time, as the nerve fibres suffer, sensation may be perverted or even lessened. The constitutional disturbance which may attend the onset subsides in a few days, but the pain and other symptoms may persist in great severity for weeks, ultimately subsiding into a chronic stage. The muscles may waste, and present the reaction of a degeneration when tested with electricity. If the

neuritis reaches the plexus from which the nerve proceeds, it may affect all the nerves of the limb. The rheumatic forms are apt to be much more tedious than those resulting from injury. The symptoms and the course of neuritis will vary according to whether the nerves affected are sensory, motor, or of mixed formation.

Diagnosis.—This depends, *first*, on the localization of the symptoms to the distribution of a certain nerve-trunk; *second*, on the pain and tenderness *in the nerve*, which is increased greatly by pinching or pressure. An attack may at first be taken for rheumatism or a simple myalgia; but in a day or two the localization of the symptoms declares their nature. Or it may be taken for neuralgia; but in neuralgia the pain intermits more completely than in neuritis, and there is not the same initial tenderness in the nerve-trunks. Lessened sensibility, showing organic damage to the nerve-fibres, is conclusive evidence of neuritis.

Prognosis.—Complete recovery must be promised with great caution, though of course more can be accomplished by homœopathic than any other treatment. Very discouraging are cases of long duration, and where symptoms of paralysis and trophic disturbance appear. The gravest form of single neuritis is the termination in a local suppurative inflammation. Generally the prognosis is best in traumatic neuritis. The rheumatic form is usually less severe than the traumatic.

Treatment.—First, remove the cause, if such can be found. An injury or local inflammation adjacent to the nerve must be appropriately dealt with. A constitutional cause, as gout, must be treated. Complete rest of the inflamed nerve is of the utmost importance. Next, the position of the limb should be such as to involve no pressure or tension of the nerve. The general treatment is such as would be for any acute local inflammation. Diet should be unstimulating. Hot applications, or hot poultices may be used—care being taken not to blister the skin that is anæsthetic, or ulceration may result.

Gowers gives the most excellent caution, that while injections of morphia and cocaine may be used to subdue the pain, the limb is on no account to be used because the pain is not felt. “Mechanical irritation,” he says, “may be equally injurious, although the pain which it would cause is obviated by the sedative.”

Electricity is of but little, if any, benefit during the acute stage. The muscles supplied by the inflamed nerve should be let alone, except a gentle rubbing once or twice a day, unless their wasting is

marked. If the wasting is considerable, or there is degenerative reaction, they may be stimulated to gentle contraction by a weak, interrupted current. They should on no account be faradized during the active stage of the affection, as the acute pain that the faradic stimulant causes, and of the increased tenderness that lasts for hours afterwards, are sufficient evidence of its injurious effect.

In all cases attention to the general health is of great importance, and change of air will sometimes remove, in a few weeks, symptoms that have been stationary for months. *Rest, absolute rest*, of the affected part must be positively insisted upon.

Remedies.—As in any other affection, any remedy in the *materia medica* may be called for, and, if well chosen, will be sure to bring prompt relief, and to cure the case without any sequelæ.

I will offer, as suggestions, the special consideration of *acon*, *agar mus.*, *arn.*, *ars.*, *bry.*, *bell.*, *cham.*, (*china?*), *coff.*, *ferr. phos.*, *gels.*, *magnes. phos.*, *merc.*, *nux vom.*, *puls.*, *rhus tox.*

Perhaps, also, *hyperic.*, *coloc.*, *cocculus*.

In *chronic* cases, particularly where accompanied by paralysis or wasting, the galvanic current, applied daily to the affected spot, for a few minutes, is said to produce prompt and marked improvement.

A CASE OF HÆMATOMA, INVOLVING THE OVARY, FALLOPIAN TUBE, AND BROAD LIGAMENT.

[With Three Photographs of Specimens.]

BY THEODORE J. GRAMM, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania,
September 20, 1893.)

DESPITE the fact that no conclusions can be drawn from isolated cases, the fact remains that the accurate report of a single case cannot fail to be instructive and interesting. The following case is not intended to urge any theory, but forcibly suggests that the pathology of many pelvic diseases is the key to the solution of some vexatious problems concerning treatment which have engaged the attention of physicians and abdominal surgeons who would conform to the so-called recent reaction against unnecessary abdominal section.

My patient was a young woman of twenty-five years, whom I had operated some months before for a distressing condition brought

about by an internal laceration of the muscles of the pelvic floor. While under ether I made the usual careful palpation of the uterine adnexa, and more accurately outlined an enlarged right ovary which had already been under observation. I predicted that that ovary would ultimately require removal. Despite my conviction, I determined to try to avoid an abdominal section by careful medicinal, mechanical and hygienic treatment, especially in view of the fact that three years before the patient had given birth to a healthy child. The course pursued was strengthened by the fact that in view of the delightful relief which the patient received from the perineal operation she persistently demanded abdominal section, being urged thereto by some friends who had been successfully operated.

The most painstaking and careful medicinal treatment was applied, remedies being given only after careful study ; at the same time that the patient was probably under the most favorable hygienic conditions that surround any one ; while sexual intercourse was not at all indulged in. In this way six months passed, and the patient was no better.

Her history was about as follows : As a child she had enjoyed ordinary health, but since puberty has not been robust, and always complained of pain in the right side of the pelvis. This was incessant and distressing, and when standing compelled her to flex the knee. At certain intervals she suffered from acute attacks of pain which confined her to bed, the attending physician diagnosing neuralgia of the bowels or bladder. The menstrual period recurred normally, and lasted five days or longer, with much pain in the right pelvis. She married and two years after gave birth to a large male child. A submucous laceration of the pelvic floor occurred during the delivery, and from then on her general condition was much worse, the ailments resulting from this condition being added to her already asthenic state. So she continued until her child was three years old when I first saw her, and after a short preliminary treatment she was operated for attenuated pelvic floor.

She made a good recovery from this operation, but there was no diminution of the ovarian pains ; nor was she much benefited after six months' careful treatment. This consisted in the administration of remedies carefully selected, local treatment tending to reduce pelvic congestion such as vaginal douches, alterative applications and the occasional use of a pe-sary, in addition to careful attention to hygiene.

She still suffered from aching, soreness, and cutting pains in the

right ovarian region, or a "scraping" and burning pain. There was some swelling of the right thigh and leg, with sensation of heaviness and occasional pains going downward from the pelvis; also a feeling of numbness and tingling. There was much soreness in the abdomen, and when sitting down had sensation of pressure upwards in the rectum and vagina.

There was great physical weakness especially at the time of the menses. Her face was quite colorless and thin, with dark rings about the eyes.

Physical examination: externally, abdomen quite normal in appearance and relative measurements, but patient cannot bear any pressure in right ovarian region, though no abnormal mass can be felt. The perinæum and pelvic floor, restored by operation, are now functionally normal; as also the vagina and cervix uteri. The corpus uteri was rather inclined to be erect in the pelvis and somewhat displaced to the right side. The left ovary could be felt of normal size, but somewhat sensitive. Interest, however, centered in the condition of the right ovary. It could be felt by pressure directed laterally or somewhat toward the back and was always found to be enlarged, apparently about three inches in length in the diameter usually felt. It was quite sensitive to touch.

During July she resumed marital relations. At the end of the month her period came on, but was attended by persistent nausea, especially in the morning, and was aggravated by the sight and smell of food. This symptom while it had occurred before, never was so pronounced nor had it ever lasted longer than a few days at a time. Now, however, it was persistent and continued for about six weeks.

After this time my patient appeared to be materially worse in general. The abdomen was more sore, and the right ovary much more painful. There were cutting and bursting and burning pains in the ovary, going up to the region of the heart and causing difficult respiration. Numb feelings over the body, as of being etherized; physical weakness much increased; must constantly flex the right knee. On examination by the vagina, the right ovary was felt to be increased in size.

In November this patient was suddenly taken, without apparent cause, at night, while in bed, with severe pain in the right side of the abdomen, which she described as cutting and bursting, and attended by great soreness in the abdomen. There was nausea, vomiting, great prostration and shock, and the soreness in the abdomen,

to touch, either in the vagina or externally, or from any voluntary motion on her part, was intense.

The following evening, though living some distance from the city, I visited her. She had then reacted somewhat, the pulse being 90 and the temperature 99.5° .

On vaginal examination, there was found to the right of the cervix, and lying close to it, a large, excessively sensitive mass, movable and presenting certain irregularities when palpated, and behind the uterus another mass was felt which was thought to be the enlarged right ovary. The menstrual period had occurred once a month, and the patient was bleeding now, although several days before her time.

From these conditions I found a diagnosis of hæmatoma, probably involving a cystic ovary, was made, and abdominal section advised. This was done, four days after, at my private operating rooms in Philadelphia, the patient having improved somewhat after the first serious symptoms had subsided.

The operation itself was without particular interest and was easily performed. The masses in the right pelvis were not engaged in inflammatory adhesions, and so were easily removed. The left ovary and tube, though apparently normal, except much congested, were also removed, in compliance with a promise exacted by the patient.

The specimens from this case I regarded at once as having peculiar interest. When the specimen from the right side was delivered it presented a striking contrast to the blanched abdomen, for it was of a deep-red color, almost black, and the broad ligament was at once seen to be distended with blood apparently to its utmost capacity and almost ready to burst. The enlarged and flattened ovary measured $5\frac{1}{2}$ c.m. by $4\frac{1}{2}$ c.m. by $2\frac{1}{2}$ c.m. The broad ligament is distended with blood, and where the vessels enter it measures 2 c.m. in diameter. This expands outward into a sac about 5 c.m. in diameter, the upper surface of which is continuous with the upper surface of the tube, with no crease or fold which would mark the lower border of the tube. The tube therefore loses itself in this dilated portion of the broad ligament, like the neck into the body of a retort. The tube is elongated into $11\frac{1}{2}$ c.m. Its average diameter up to where it nears the sac is 1 c.m. The fimbriated extremity is much enlarged, apparently hypertrophied, as shown in the photographs. The hæmorrhage bulged out the anterior fold of the broad ligament more than the posterior.

The left ovary and tube are normal, except that the tube was

much congested at the time of operation. On cutting through the right Fallopian tube, its entire lumen is found to be occluded by tissue which macroscopically resembles inflammatory tissue. On cutting through the distended broad ligament, a cavity is opened into, not apparently connected with the lumen of the tube, containing a blood clot and lined by a comparatively smooth membrane, which can be readily separated from its surrounding tissues.

The accompanying photographs give a fair illustration of the appearance of the specimens.

FIG. 1.

Fig. 1 shows the posterior aspect of the right tube and ovary. The greatly-enlarged fimbriae of the tube attract special attention. The smallest diameter of the ovary is presented in this view.

In Fig. 2 the anterior view is seen. Here is displayed the broad ligament distended with blood and the large vessels entering it. To the right and below is seen the ovary, again showing its thickness. Above is the Fallopian tube, which gradually loses itself above and behind in the distended broad ligament, like the neck entering the body of a retort, and again appears below in the thickened fimbriae.

FIG. 2.

FIG. 3.

Fig. 3 is a view from below upwards, and displays the shape of the ovary in its length and breadth. Both ends of the tube, the distended broad ligament and the place where the vessels enter it are seen around the ovary when looked at from this direction.

These specimens, as above intimated, may be regarded as having peculiar interest, on account of the long time the patient was under observation, and the failure to give relief by the treatment applied, which, on the contrary, evidently only temporized until a dangerous complication occurred, which threatened the patient's life immediately or remotely. But the specimens are mainly of interest because this complication is most likely an early tubal pregnancy which ruptured into the broad ligament, and on that account I have taken some pains to represent the specimens.

Unfortunately, I am not at present prepared to give the completed microscopic evidence bearing on this point, but no other theory save this conforms to the history of the patient or can explain the microscopic appearances seen in the sections so far examined. This aspect of the case, however, belongs to another bureau.

SUBMAXILLARY MUMPS.—Dr. Wertheimer, of Munich, has observed three cases of submaxillary mumps which is a relatively rare localization of the disease. After the parotid the submaxillary is most often attacked, and very infrequently the sublingual. A large number of cases have been reported. Leitzen observed out of 77 cases of mumps, six cases where the submaxillary alone was invaded, and one of the sublingual. As rare anomalies may be cited, those cases where all the salivary glands are spared and only the cervical lymphatics are attacked, or an orchitis appears. Leube asserts that the pancreas may also be involved. In one it was interesting to note the high fever and grave disturbance of the general condition, with but slight localization in the gland—a further proof that the gravity of the general reaction not being in relation with the importance of the organ attacked, but rather in dependence upon the virulence of the poison, and the individual state of the patient. A confusion of this disease with other affections is only at the beginning easy. A sympathetic swelling of this gland may occur in inflammatory affections of the neighboring regions as in diphtheria of the fauces, phlegmonous angina, ulcerative stomatitis, eczema, and herpes of the face, etc. Periostitis of the lower jaw is easily confounded, as it is often observed in little children with carious teeth. In such cases the tumor is unilateral, of a tense and hard consistence, firmly attached to the bone, the skin over it tensely distended and shining and beginning to show a redness. It is more sensitive than submaxillary mumps. Acute lymphadenitis may greatly resemble the latter condition, but the tumor begins as a small and painful gland and increases to a compact and painful mass. Acute phlegmon of the submaxillary gland, angina ludovici, actinomycosis, etc., are differentiated by the brawny infiltrate from the very first, and thereby greater painfulness. Again they are only unilateral and their further course different. (Dr. Wacker, in the same journal, reports a case of the same disease in a boy of five years, whose mother afterwards fell sick with double parotiditis, while in the same house there were three other persons sick with typical mumps.)—*Muenchener Medicinische Wochenschrift*, No. 35, 1893.

EDITORIAL.

WATER—FROM A CHEMICAL AND BACTERIOLOGICAL STANDPOINT.

It is not so long since the wholesomeness or unwholesomeness of drinking-water was supposed to be determined with sufficient accuracy by a chemical analysis, by ascertaining the total solids and the total organic matter. The development of the science of bacteriology, however, with its methods of bacteria culture, has slowly but surely opened the eyes of sanitarians to the fact that the data obtained through chemistry, no matter how refined the method of analysis, must be supplemented by others before a strictly correct judgment can be pronounced upon the potability of any given sample of water. The importance of obtaining its "natural history," as Reafter so well calls it, is now being generally recognized.

The *Report of the Lancel's Special Analytical Sanitary Commission* on the character and quality of the ice supply of London illustrates this point most strikingly, since the analysis resolved itself naturally into an examination of the water obtained from melting the solid ice, under suitable precautions to prevent contamination.

Examinations were made of six specimens, one of artificial ice, purchased directly from the city ice company, and the others of Norwegian ice, procured from various restaurants in the city.

The chemical analysis showed that with the exception of the first sample, that from artificial ice, all were derived from water of a chemical purity approaching that of distilled water. A series of gelatine plate cultures, however, was made in addition from each sample, five plates in each series, with the following results:

In one sample, that derived from artificial ice, but one species was found, producing but from 1 to 6 colonies on plates kept at the temperature of the room. In two other samples from Norwegian ice, under the same conditions, six different species were found, producing between 500 and 600 colonies per c.c. In three others, also from Norwegian ice, two and three species, with from 35 to 70 colonies per c.c., were developed.

Hence, by a bacteriological examination, that specimen upon which chemical analysis had thrown a shade of suspicion proved to be a very good sample of pure ice, while of those which seemed chemi-

cally almost as pure as distilled water, two showed themselves to be absolutely bad, while the three remaining ones could be classed only as of fairly good quality.

Interesting, also, in this connection, is the report of four fatal cases of typhoid fever at Paterson, N. J., due to the use of water from artesian wells. Forty cases are said to have occurred in about a month in a limited district, where the supply is drawn largely from artesian wells. In a single block of that district fourteen cases were reported. Dr. Wallace, State Chemist, examined the water, and found it to be heavily loaded with impurities.

As casting a sort of side light upon the above, we find it said that an epidemic of typhoid fever broke out along the banks of the Tiber among the workmen and those living in the vicinity, on excavating in the bed of the river and removing a deposit of soil which was proved, by coins and other relics found in it, to date from the fourth century A. D.

It seems as if bacteria were rather getting the better of us. We boil them and bake them, we filter them and bury them, and still they come up smiling. Is life worth the living if it be lived with an ever present consciousness that every breath we draw puts inside of us countless disease-germs; that everything we touch, taste, or swallow is covered with micro-organisms, bent on our destruction, and that it is only owing to the eternal but unrecognized and unrewarded vigilance of similar microscopic care-takers that we are not all dead men?

If in spite of the blessed ignorance of previous generations, the human race still managed to increase and multiply to the extent that it has done, it will not take long to fill the earth if we continue to chase these tiny destroyers to their fastnesses, and rout them out with disinfectants, to follow them into their new strongholds and cause them miserably to perish by our antiseptics. By our bouillons, agar-agar and potatoes, we learn to know their little peculiarities and will soon learn to laugh at them—in our laboratories, and perhaps, to render them harmless in our bodies. Either these organisms have increased in virulence and threaten us more than they did our ancestors, or, our efforts at sanitation will soon render necessary a flood, or a few earthquakes, or some other natural means of clearing the decks and allowing only the fittest to survive.

PSCHYOPATHIA SEXUALIS COMSTOCKII.

WE see that A. Comstock (*i.e.*, *the* Comstock) by his authority as inspector of mails of the United States has caused the arrest of B. B. Daggert, manager of the Daggert Table Company, charging violation of the postal law, because of certain prints illustrating uses of the table advertised. He said that medical journals, or any other matter containing prints which exposed the genital organs, or any part of them, no matter for what purpose, would be suppressed and prohibited from entering the mails.

It is with difficulty that we restrain ourselves and prepare to treat this matter with the solemnity which the danger threatened demands. Shall such a person be allowed to act as censor not only of morals, but of medicine and medical literature? His fiat would effectually put an end to the transmission by mail of all works on anatomy, physiology, general surgery, obstetrics, gynæcology, in short, of the greater number of medical works, besides the numerous periodicals which in the interests both of their contributors and subscribers vie with each other in presenting to the eye illustrations explanatory of the letter-press. Would this not be a gross encroachment upon the liberties of individuals, both as citizens and as physicians? Were these illustrations sent broadcast over the land, and posted on every fence, as are the advertisements of female regulators, some objection might be raised; but being contained in journals intended for the medical profession, and sent only to members of the same, or to the publishers of medical literature and dealers in surgical instruments, a decision in Comstock's favor would be fraught with dangers to our profession, the far-reaching consequences of which it would be difficult to estimate. We trust he may receive his quietus.

If he can recognize no difference between prints such as he, by his late action, condemns, and those for the suppression of which he has (very unwisely, we think) had conferred upon him a degree of authority quite at variance with the spirit of our institutions and his own qualifications—why then the sooner he becomes a private citizen the better. His own morality need not then be judged only by the amount of supposed immorality that a prurient fancy can succeed in ferreting out.

We say this not altogether in anger; we are moved by a sincere pity for the man. What must be his lamentable state whose every sleeping and waking thought is directed to unveiling lascivious ideas, to finding possible sources of vile thoughts and desires! How is

he to be pitied who has made it his object in life to rake up smut! What has he done, here or perhaps in some previous state of existence, to be tormented thus? The temptations of that other poor St. Anthony, to judge by their classic representations, were nothing compared to those that beset this one. The former could have found æsthetic pleasure in a contemplation of what Nature has made altogether beautiful, but this latter-day saint can find nothing purely beautiful; nothing but what is suggestive of evil; nothing but what is tainted by his mind diseased. Those naughty, naughty genitalia to torment him so! To peep out at him even from the recesses of a mail-pouch, even through the wrappers of modest-looking journals! Why was Nature so inconsiderate as to confer upon them so much importance? Why did she depart from her original asexual standpoint, and, in the process of evolution, differentiate more and more those horrid, horrid things? Our confidence in Dame Nature's discretion is almost shaken, and we would propose, as a worthy aim of science in the future, an attempt to get rid of these seeming after-thoughts of hers. Until this consummation be attained, let us endeavor to endure their presence as patiently and modestly as may be, and pray that Mr. C. may not be empowered by new laws entirely to suppress them, as he is inclined to do their innocent representatives.

CONDITIONS SIMULATING RENAL COLIC.—Dr. Tuffier, of Paris, in a lecture at the Hôpital Beaujon, considered those states resembling renal colic. A calculus retained in the pelvis of the kidney will give rise to similar symptoms, renal colic without expulsion, but it is very rare. Here the pain is generally lumbar, fixed, with irradiation into special regions and following one or two typical attacks of colic. It is increased by movement, hæmaturia is rarely absent, and a small stone or a quantity of gravel is generally expelled. The painful symptom complex of pseudo-nephritic colic is met with in movable kidney with or without intermittent hydronephrosis, renal tuberculosis, pyelitis, neoplasms, and in certain congestive states of the kidneys. There are two classes of states which may produce a condition resembling renal lithiasis with colic without lithiasis; the first are those capable of producing a total and sudden obstruction of the ureter. Pyelo-nephritis is accompanied by painful complications, but the febrile state suffices to differentiate. Intermittent hydronephrosis is associated with the same painful attack, but the kidney increases in volume, and there is consecutive polyuria. Distension of the renal pelvis after with expulsion of hydatids or with the hæmorrhage from an epithelioma of the kidney accompanied by attacks of hæmaturia may give rise to painful attacks simulating renal colic, but often there is expelled a long and fibrous clot which bears the impress of the ureter. The second class is associated with undoubted attacks of renal colic without lithiasis and without apparent cause of obstruction of the ureter. Intermittent hydronephrosis, mobility of the kidney, renal tuberculosis with possible secondary localization in the testicle, are examples. Vascular disturbances from interference with renal circulation undoubtedly play here an important rôle, especially of the venous current.—*La Semaine Médicale*, No. 61, 1893.

GLEANINGS.

GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D., AND FRANK H. PRITCHARD, M.D.

EPILEPSY AND HEART DISEASE.—Dr. Heinrich Rosin describes an epileptic condition dependent upon disease of the heart and the great vessels. The case which forms the nucleus of his communication was that of a woman of 62 years who succumbed, after thirteen years. Up to the beginning of her disease she was always healthy, a picture of blooming health. No negative family history. It began with paroxysmal attacks of tachycardia, appearing every six to nine weeks, and lasting a few hours. They appeared and disappeared suddenly. During the attack her face was pale, profuse, thin, and colorless urine, purring and irregular heart's action, sense of oppression and disagreeableness. In the course of the following few years they increased in frequency, to set in every two or three days for three or four hours, chiefly towards evening. Examination of heart and urine revealed nothing abnormal though a degeneration of the myocardium of arterio-sclerotic nature was assumed, on account of arrhythmia which developed later, an enlargement of the heart, and accentuation of the second aortic sound and a tortuosity and hardness of the peripheral arteries. The heart sounds were clear and the urine free from abnormal constituents. This condition persisted for seven years with oppression and indications of a tendency to angina pectoris on rapid or long walking. In the third year of her disease she was one night seized with a typical epileptic attack. During the following ten years she had seven attacks, all beginning at night and during deep sleep. The last three attacks were especially severe, while the seventh and eighth consisted of three to four, one following one another at intervals of half an hour. No disagreeable after-effects. No paralysis of any kind. The last and eighth seizure was fatal; she did not awaken from her stupor, cardiac weakness set in and pulmonary œdema and death followed. He regards the seizures as due to an affection of the bloodvessels. He concludes that:

Diseases of the heart and bloodvessels may be the cause of epilepsy. It is to be traced to the cardiac disease when all other causes have been eliminated. This cardiac epilepsy may be associated with all forms of heart disease, but degeneration of the myocardium and arterio-sclerosis appear to be especially liable. It is dependent on a disturbance of nutrition of the brain from changes in the circulation. The attack is prone to appear during sleep.—*Wiener Medizinische Presse*, No. 43, 1893.

A CASE OF STENOSIS OF THE CORONARY ARTERY WITH A PULSE BEAT OF EIGHT PER MINUTE.—Dr. Kr. Freng, of Christiania, reports an interesting case in a sailor of 59 years, who after a history of several years of rheumatism commenced to develop symptoms of a heart affection, for six years, suffering with palpitation, oppression, præcordial pain, which extended into the left arm, coming on in paroxysms and terminating in fainting. During the latter months of his disease these seizures would appear often every five minutes and be accompanied by convulsions. The pulse varied, in frequency, from twenty-six to eight per minute and presented a remarkable strength and regularity. Auscultation only revealed during this whole time a systolic murmur at the apex. He died, and the necropsy demonstrated the existence of adhesions between the two layers of the pericardium, a recent deposit of fibrine in this membrane, slight hypertrophy of the left side of the heart, atheromatosis of the aorta and its valves, an incrustation of the mitral valves, as well as stenosis of the coronary artery without fatty degeneration of the myocardium — *Norsk Magazin for Lægevidenskaben*, No. 7. 1893.

CONTAGION AND HEREDITY IN TUBERCULOSIS.—Dr. Herard, at the Third Congress for the study of tuberculosis, held at Paris, recently, read a paper on this sub-

ject. It has been asserted that tuberculous parents transmit only a weakened constitution and an increased tendency to their children to acquiring tuberculosis, and from this point of view, the micro-organism is the only source of the disease. This he cannot hold for if one see two or three children of the same family die of tuberculous meningitis, at an early age, it goes to demonstrate that something more than the tendency is transmitted. He recapitulates as follows:

1. Contagion is the most frequent source of pulmonary tuberculosis.
2. Heredity is an established fact. Not only is an augmented tendency transmitted to the children but the germ itself is frequently inherited.
3. In external and primary tuberculosis heredity plays a prepondering part.—*Revista de Ciencias Medicas de Barcelona*, No. 18, 1893.

NERVOUS DISTURBANCES OF PHTHISIS PULMONALIS.—Dr. Weill claims that pulmonary phthisis in four cases out of ten is associated with a peculiar nervous syndrome which is characterized by profound muscular, osseous, and articular hemi-hyperæsthesia. It may be independent of spontaneous pains, may spread over the whole body but it usually predominates on one side. Muscular sensitiveness is most constant, precedes the others and is last to disappear. They are only transient phenomena and last from a few days to two months. They are not in relation to the gravity of pulmonary lesion but in most cases there is a parallelism. It is especially prone to be observed in that form associated with erethism, coughing by attacks, seizures of oppression, vomiting and palpitation. They greatly resemble hysteric stigmata. It is due neither to an action of the bacillus nor a microbic intoxication but to a centripal irritation, with the point of departure in the sensory nerves of the lungs and bronchi.—*Raccoglitore Medico*, No. 10, 1893.

EARLY DIAGNOSIS OF CHRONIC NEPHRITIS.—Prof. Penzoldt of Erlangen, finds that excessive exercise, inordinate ingestion of certain foods, as asparagus and radishes, as well as certain drinks, as alcoholic beverages, tea, coffee, together with mustard, will determine abnormal irritative conditions of the kidneys, which, with an individual disposition, may be the cause of chronic nephritis. He has found that these foods and beverages, condiment, etc., will, in a healthy person, give rise to leucocytes, red blood-corpuscles and casts in the urine, epithelium. Not the single day's use of any of these, but the accumulated and day-in-and-day-out employment of such irritating substances will lead to chronic nephritis. Diagnostically red blood-corpuscles are abnormal if found for some time in the urine, though it is difficult to determine if they are from the kidneys. Centrifugation is an important aid. Prescribe strict rest of body, and avoidance of all irritative foods and drinks, especially alcoholic, and the articles mentioned, and examine repeatedly the sediment by the centrifuge. If the results are the same as under ordinary conditions, the existence of a chronic nephritis may be safely assumed. He has been able, in cases even before the appearance of albuminuria, to diagnosticate the existence of a chronic nephritis by the presence of renal epithelium, leucocytes, and casts. He recommends the centrifuge in cases where there is none or but traces of albumin; an exact diagnosis is impossible, and when the affection is in its initial stage where a recovery is possible. In its later stages it is certainly hopeless to diagnosticate it.—*Muenchener Medicinische Wochenschrift*, No. 12, 1893.

DIFFERENTIAL DIAGNOSIS OF THE VARIOUS FORMS OF CONVULSIONS IN YOUNG CHILDREN.—Dr. Landon Carter Gray, in discussing this subject before the New York Academy of Medicine, said that it involved the consideration of a large number of diseases, for a convulsion is a symptom, and not in itself a disease. A broad general classification of convulsions might be made into organic and functional. We know very little about cerebellar disease in the child, and our attention must be directed entirely to the cerebrum. In the organic class are the convulsions due to meningitis, encephalitis, meningo-encephalitis and hydrocephalus. An organic lesion may be suspected when there is paralysis of some function of the cerebrum, as of sight or hearing. Cerebral hæmorrhage may alone cause convulsions, and may be local or wide-spread. Organic lesions in the brain may cause convulsions, and may also impair mental power. Recently much has been said regarding the possibility of mental disturbance due to premature ossification of the bones of the skull. Lannelongue's operation has become a fad. It is useless, however, where there is distinct evidence of an organic lesion, as paralysis, blindness, or deafness. It can be of value only when the mental power is reduced.

A most interesting subject is that of functional convulsions. Chorea is sometimes mistaken for disorders of convulsive nature. Chorea appears under two forms. In the one the movements are fibrillary and very quick in their occurrence, and beyond the control of the patient; in the other, motions are more gradual and worm-like. Experiments have recently been made regarding convulsions due to digestive disturbance. It has been found that the normal putrefaction which always occurs during digestion, sometimes becomes abnormal or irritative. In these cases the patient is slightly dyspeptic, and indican may be detected in the urine. These investigations are interesting and important, as they throw light upon facts which have long been known regarding the close association of digestive disorders and convulsions. Peripheral irritation has long been considered a cause of convulsions. There is no positive proof that ovarian disease ever of itself causes convulsions. Removal of the disorder is rarely followed by more than temporary relief. True epilepsy is marked by paroxysms which occur in series. This fact must be considered in discussing the disease, and in drawing conclusions regarding the treatment. No one can say at what period epilepsy is cured. The convulsions sometimes appear months or even years after a cure has apparently been effected.

THE PROPERTIES OF WAYIKA ARROW POISON.—In a paper read before the Royal Society, Prof. Fraser and Dr. Tillie give interesting pharmacological and physiological particulars of the active principle obtained from the wood of a species of *Acocanthera*. This active principle is the Wayika poison. It occurs in the form of colorless, thin, needle-shaped crystals, which usually group themselves in tufts and rosettes. When crystallized from water, the plates are quadrangular. The physiological action of the poison was studied on frogs and rabbits.

In large lethal doses, there were noticed slowing of respiration, fibrillary twitching of the muscles, impairment of motor power and co-ordination, enfeeblement, and loss of reflex and voluntary motion, and death with the ventricles in extreme systole, while the auricles were distended with blood, and the whole heart rapidly became irresponsive to mechanical and electrical stimulation. In small doses, whilst response to stimulation remained for a time, the heart was arrested in extreme systole. Motor power is usually much reduced before death. The respiratory phenomena are due to the arrest of circulation; and the fibrillary twitchings to a primary action on the motor nerve endings. The abolition of reflex and voluntary movements result from paralysis of the nerve-centers, not from peripheral action. This central paralysis is due almost entirely to the failure of the circulation. The motor nerves retain their influence upon the muscles until the latter show distinct signs of poisoning, but the muscles still react to strong electric stimulation, after stimulation of their motor nerves is no longer able to excite contractions. During the progress of the effects of the poison on the heart, the inhibitory function of the vagus is retained, and even increased; but diastolic arrest is apparently due to a direct action of the poison on the motor ganglia and muscles of the heart. The action on the bloodvessels is very slight, in this way differing much from the influence of digitalin. The whole action of the agent reveals its great resemblance to, if not identity with, strophanthin.—*Lancet*.

POISONING BY EUCALYPTUS OIL.—Dr. Neale reports a fatal case of poisoning by eucalyptus oil in a boy *æt.* 10 years. On arrival the writer found him dying; lips and gums colorless; chest and neck rigid; the breath coming in gasps; and the pulse too feeble and too rapid to count. He died in twenty minutes.

The history was that several of the family had colds; that at 9 o'clock on the previous evening, the boy who was quite well, took some blue-gum oil as a preventive, stating the same to his father, and went to bed. In a few minutes the father was attracted by his gasping for breath, and went to him, when the boy vomited heavily. This relieved him and he breathed well for an hour, when the struggle for air came on again, and increased until death, fifteen hours after the ingestion of the oil. There was no purging; only one vomit; no convulsion. He spoke rationally several times up to within an hour of death; once complained of pain in the right axillary line above the liver, relieved by a poultice.

The inquest showed that a little over half an ounce had been taken. The post-mortem appearances were as follows: Forty-eight hours after death post-mortem congestion was well marked over the whole back and neck; the abdomen and loins were greenish; no corrosive marks in mouth or pharynx; stomach much distended with gas, and on perforation collapsed to less than a third. It contained a small

quantity of thick yellow, odorless fluid. The outer surface was white, except for a staining where it adjoined the spleen; inner surface white, thickened and puckered, as if painted with a mild solution of carbolic acid; not brittle; liver, spleen, kidneys, and intestines healthy. Pleural cavities contained a quart of serum, not flocculent; no lymph on pleuræ, nor thickening; both lungs collapsed, firm, and bloodless, colored in patches of pink and white, except posteriorly, where stained with the pleural fluid. Right heart contained frothy fluid, the left empty and contracted; the brain soft and pulpy, the membranes only being full of blood.

Since the inquest, the author has heard of several authenticated cases where serious symptoms have followed a dose of one drachm of eucalyptus oil, in all instances with catching of the breath, and followed by recovery.—*Australian Medical Gazette*, April, 1893.

CHLOROSIS.—The causation of chlorosis has been brought nearer elucidation by Dr. Stockman's very interesting investigation on the utility of iron and its mode of action. There are two theories to account for chlorosis. One is that ptomaines are formed in the bowels, and act directly on the organic iron of the food in such a way as to prevent its absorption. The other theory is that the organic iron is absorbed, but the cause of chlorosis is a derangement of the metabolism of the blood-forming organs preventing proper use being made of the organic iron, which therefore accumulates in the liver or other organs, or is excreted in the urine. Assuming the correctness of this theory, there are three ways of accounting for the abnormal metabolism: (1) The disease may be regarded as a neurosis allied to hysteria, the splanchnic nerves being affected, and the disturbed metabolism is a consequence of the mental state. (2) Or an absorption of ptomaines occurs from the bowels as a consequence of congestion of the bowels, and this affords an explanation for the occurrence of the disease in girls about the age of puberty, for then pelvic hyperæmia occurs. (3) Or the theory of a neurosis can be combined with the ptomaine theory by holding that the mental state affects the nutrition of the bowel directly and permits of toxic absorption. If the somewhat speculative theory that ptomaines are normally absorbed from the bowel and destroyed in the liver be adopted, then the entrance of ptomaines must be conceived as taking place in the liver. The objection to the ptomaine theory is that ptomaine poisoning or auto-infection is now being put forward to account for several diseases. An intestinal toxin cannot produce all sorts of diseases; and if we assume the existence of several toxins and the absorption of only one at a time, the matter becomes very complicated.—*British Medical Journal*, 1893.

A CASE OF SIMPLE INTESTINAL OBSTRUCTION SUCCESSFULLY TREATED BY INJECTIONS OF TOBACCO INFUSION.—Dr. E. R. Carcia, of the city of Mexico was called to a patient with the symptoms of intestinal obstruction not such as follow invagination, incarceration, etc., but rather those of simple intestinal obstruction from paralysis of the intestine, for the symptoms had lasted for eleven days when he called in. He made an infusion of seven to eight quarts of strong tobacco and after the introduction of an œsophageal tube nearly wholly into the rectum, he injected three syringesful, one after the other, which were immediately expelled in succession. On attempting to inject the third quart a quantity of gas was passed. After expulsion of the third injection the gases continued to be passed by the rectum with abundant intestinal peristalsis. The fixed pain in the abdomen diminished in intensity. A fourth injection was attempted when, after the introduction of the half of the quantity, the patient was seized with an imperious desire for a stool, and a quantity of liquid, containing hardened balls of feces of a stinking odor, were passed. The injections were continued, one after the other, until the whole intestine was emptied. The condition of the patient immediately changed from *in extremis* to the very contrary, and after a cup of tea with some brandy in it, he was given a purgative, and recovered without further difficulty. The writer has employed the infusion of tobacco in intestinal obstruction since 1885 and in many cases with success. He recommends in such cases an immediate recourse to infusions of tobacco by the rectum.—*Gaceta Médica de Mexico*, No. 6, 1893.

CHLORIDE OF BARIUM IN EPILEPSY.—Dr. Lisle has given the chloride of barium, in doses of 8 mgms. to 3 cgms., in epilepsy with good results every four hours.—*La Semaine Médicale*, No. 52, 1893.

GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D.

DIVULSION OF URETHRAL STRICTURES.—C. L. Scudder (Boston) has made a study of four hundred and four cases of urethral stricture operated by divulsion alone, with the instrument of Bigelow, at the Massachusetts General Hospital during the past twelve years. Most of them were tight, producing acute retention, while the condition of the patients was poor. About two per cent. died; six per cent. had chills; the average temperature was over 100°; the stay in the hospital averaged twelve days; and almost all wore the inlying catheter. A comparison based on the location of the stricture is not made. The majority were treated without reference to the relation between the urethra and the circumference of the penis (Otis). When the sound was not subsequently used at regular intervals most of them relapsed.

The following conclusions are drawn:

1. The Bigelow divulsor is a safe, simple and efficient instrument.
2. Considering that the operation was a routine one, the mortality is low, and should lead one to suppose that in properly selected cases it would be still lower.
3. After divulsion the amount of constitutional disturbance was comparatively slight. The urgency of the symptoms was usually so great as to preclude preliminary preparation. With recent methods of urinary asepsis and urethral antisepsis even less constitutional disturbance should follow.
4. Taking all things in consideration the permanence of results in this series, as compared with other methods, seems fairly satisfactory.
5. In many instances divulsion probably increases the cicatricial tissue surrounding the urethra, because the rupture sometimes occurs in stricture tissue and extends into healthy tissue.
6. The operation with the Bigelow divulsor is not regarded by those familiar with it "as violence applied to the urethra in a rude fashion," but as a method at once accurate, easy, ready, safe and almost bloodless.
7. There is a distinct and rational place for divulsion as a surgical procedure:
 - a. In firm, tough stricture divulsion is contraindicated.
 - b. There are soft strictures, but firm enough to cause retention of urine, which yield to very little force, and it is this class of stricture for which divulsion is pre-eminently the operation.
 - c. The penile stricture is almost always firm, and composed of more cicatricial tissue than is the deeper urethral stricture, and in the anterior penile urethra internal urethrotomy seems to be the better operation.
 - d. No one procedure is the operation in all cases of stricture. A careful study of the character and seat of the stricture should determine the exact operation to be done.
 - e. Divulsion with the Bigelow instrument should be reserved for soft deep strictures unaccompanied by much cicatricial tissue.—*Journal of Cutaneous and Genito-Urinary Diseases.*

EXTRACTION BY LAPAROTOMY OF A THIRTY-FOUR OUNCE CYSTIC STONE—Milton (Cairo), who has in his collection of Egyptian calculi, specimens weighing from five to fourteen ounces, claims to have removed successfully, the largest bladder stone on record. It weighed, one hour after removal without fragmentation, thirty-four and a half ounces, the next recorded one weighing twenty ounces (Dunlap, Springfield, Ohio). The patient died two and a half months after operation, and five weeks after a second calculus had been removed, from the incurable, secondary kidney changes.

The incision extended from the pubes to the umbilicus, the bladder being opened intra-peritoneally to the extent of two inches, besides the extra-peritoneal opening, which was supplemented by transverse cuts. The intra-peritoneal portion was closed with catgut, the extra-peritoneal with silk-worm gut, and the abdominal walls with silver wire, the peritonæum and bladder being drained. To this was added a perineal opening through which the second stone was removed. The diameters of the calculus were four and six inches respectively.—*Lancet.*

NEW METHOD OF EXAMINING THE LIVER.—Lane (London) reports a case in which a fibrous sac was found in the substance of the liver, which was filled with tightly packed gall-stones. This communicated by a small opening with the shrunken gall-bladder which contained three calculi. Another stone was found impacted at the junction of the cystic and hepatic ducts.

The diagnosis of tumor of the liver substance was made, excluding the previous one of distended gall-bladder, by Parkin's method, which has again and again cleared up the obscure results of an examination in the supine position. This consists in placing the patient with the trunk in a position of very considerable flexion, the weight of its upper part being taken off in order to relax thoroughly the abdominal muscles. The examiner sits behind the patient, and passing one hand around either side, palpates the upper surface, anterior edge, and under surface of the liver, together with the gall-bladder, through the flaccid parietes, with a facility that is remarkable to one who has never used the method before. A large extent of the upper surface of the organ is exposed by its downward and forward descent.—*Lancet*.

TREATMENT OF FRACTURES OF THE LEG.—Schmidt (*Wiener Medizinische Presse*) urges that fractures of the leg be treated so as to allow the patient to be up and about soon after the accident. The fractured ends are approximated, the leg placed in a hollow splint, elevated, and ice-bags applied. As soon as the swelling and effusion are reduced, in from three to six days, a plaster-of-Paris dressing is put on from the toes to the knee or above. The next day the patient is up and about on crutches, then with two canes, and finally, with one or none at all. The patient can walk, go up stairs, etc., without difficulty. If the cast gets loose it is changed in a week. A heel and sole, and a laced upper can be fitted to the dressing, which enables the patient to go out rain or shine. At the end of five weeks the dressing is removed, the limb bathed, douched, massaged, etc., until function is completely restored. A high-laced shoe is worn for some time. In case the fracture is seen immediately after its occurrence, and there be neither swelling nor articular effusion, the cast may be applied at once.

In our service at the Hahnemann Hospital, owing to the imperative demand for beds on account of the enormous accident and general surgical material, we were led, several years ago, to adopt this plan of treatment, so that fractures of the foot, ankle, leg, and even the lower end of the femur are treated as out-patients almost as soon as those of the upper extremity. The results have been thoroughly satisfactory. Occasionally, in cases seen before the development of swelling and articular effusion, and cases which could be very carefully watched, we have made use of the method which is so successful in the *ambulant* treatment of sprained ankle (vide *HAHNEMANNIAN*, page 565, August, 1893), the application of an adhesive plaster support.—Eds.

DISLOCATION OF THE HEAD OF THE RADIUS BACKWARD.—Swindells (Barking, Essex), has recently met with two examples of this comparatively rare injury, the radial head being ordinarily dislocated backward together with the ulna, and occasionally with ulnar fracture (forward usually). Both were boys, who fell on the outstretched, open hand. The symptoms were characteristic, and reduction was accomplished, as in dislocation of both bones, with the knee, and manipulation with the fingers.—*Lancet*.

THROMBOSIS OF THE LATERAL SINUS.—Bennett (London) records a successful case which presents several points of interest, and in which the diagnosis depended mainly on post-mastoid tenderness, i.e., sensitiveness to finger-tip pressure at a spot one inch behind and half an inch above the middle of the external auditory meatus.

The patient, a boy of seventeen, had been well until a month previously, when he was taken with influenza, which was followed by earache, which in turn was relieved by a discharge of pus. The next day the discharge suddenly ceased, and this was followed by a rigor and vomiting. The face was dusky and apathetic; he was aroused with difficulty; he complained of dull pain about the ear and acute frontal headache; there was post mastoid tenderness, but none over the mastoid cells; there was some discharge from the meatus, and a small abscess in the canal; the temperature was high, and the pulse sluggish; the optic discs were normal, although photophobia was present; there was no swelling along the course of the internal jugular.

The mastoid cells were opened, giving exit to a few drops of pus, and then

the lateral sinus was exposed for an inch and a half; pulsation was absent, and it was more resistant than normal; the hypodermic needle gave vent to a few drops of blood. The internal jugular was divided between ligatures at about the level of the omo-hyoid muscle. The low point of ligation was chosen to get below the lower end of the clot, which is apt to be extensive. A failure to do this brings about the very disaster the operation is intended to prevent, i.e., septic pneumonia. On the other hand, the low ligation makes it next to impossible to wash out the vein, which, however, is not considered necessary by the writer. The sinus was then laid open, and a clot about an inch and a half in length cleared out with a scoop. The bleeding, which was free, was controlled with a plug of gauze. Improvement was immediate and recovery rapid.—*Lancet*.

TREPHINING FOR BASAL HÆMORRHAGE—Chiene (*Lancet*) trephined such a case over the right parietal eminence where there was a bruise, and then in front of this point. The face was drawn to the right; the pupils were of medium size, nearly equal, and reacted to light; there was left homonymous hemianopsia and weakness of the left arm and leg. The patient was conscious, and could answer questions fairly well, but coma soon supervened. The breathing was characterized by long intermissions. The dura was incised, and the brain bulged considerably. The patient recovered consciousness after the operation, and the breathing became normal. The hemiplegic weakness and hemianopsia were present a year later. The relief of pressure as the cause of improvement is worthy of note.

A SAFE METHOD OF DIVIDING ŒSOPHAGEAL STRICTURES—Abbè (New York) recommends the following plan in dense, fibrous or impermeable strictures, following the action of caustics, as superior to external or internal œsophagotomy:

Gastrostomy, through an oblique incision parallel to the costal margins, is first performed. Retrograde, gradual dilatation is then attempted, and if this fails, a heavy silk ligature is passed up through the stricture on a fine bougie until it can be drawn out through the mouth. The largest bougie the stricture will admit is introduced through the mouth, and the operator seesaws the silk thread, until it passes the obstruction. Dilatation is carried on to the desired extent, when a tube is drawn up above the stricture, while another is passed through the fistula into the stomach. In this way the patient can swallow water and saliva without affecting the wound; dilatation is kept up, while he can be fed through the stomach-tube. In a few days the tube is removed and dilatation continued through the mouth. Subsequently the gastric fistula is closed.—*New York Medical Journal*.

TREATMENT OF PARALYTIC CLUB-FOOT BY MUSCULO-TENDINOUS TRANSPLANTATION—Phocas (Lille) reports the case of a little girl of four years with talipes valgus from infantile paralysis, where, instead of attempting an operation on the bones of the foot, he grafted the tibialis anticus tendon on to that of the extensor of the big toe. Absolutely perfect function resulted. This method of forcing unaffected muscles to do the work of those that are useless in paralytic club foot is one but little known. The subject has been referred to in the *HAHNEMANNIAN*, page 131, February, 1893.—*Le Progrès Médical*.

TREATMENT OF ANTHRAX—Goïlav (*Roumaine Médicale*) describes a method of treating carbuncle which he has used in twelve cases with success.

After washing off the affected surface with a solution of boric acid, he opens it with a crucial incision which extends beyond the diseased process into the healthy tissues. Usually no anæsthetic is necessary, although cocaine (1 per cent.) may be injected in nervous and sensitive patients. The wound is washed with the same solution and filled with boric acid crystals, not with the powdered acid, which forms a mixture with the pus and retards healing. It is then covered with sterilized gauze and a bandage.

The dressing is changed the next day, and, as a rule, the pains disappear at once and the general condition, appetite and sleep are much improved. The second dressing is not touched for nearly a week, most cases healing under three dressings, in from seven to twenty days.

The method is easily carried out, requires no anæsthetic, the dressings need but infrequent changing, and it can be used in any individual or in any portion of the body.

GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D. AND J. NICHOLAS MITCHELL, M.D.

REMOVAL OF OVARIES AND TUBES IN THE INSANE AND NEUROTIC.—Conclusions of Dr. Goodell, of Philadelphia.—From a large experience I humbly offer to the reader the following watchwords as broad helps to diagnosis. In the first place, always bear in mind what another has pithily said, that “woman has some organs outside the pelvis.” Secondly, each neurotic case will usually have a tale of fret or grief, of care and care, of wear and tear. Thirdly, scant or delayed or suppressed menstruation is far more frequently the result of nerve exhaustion than of uterine disease. Fourthly, antelexion, *per se*, is not a pathological condition; it is so when associated with sterility or with painful menstruation, and only then does it need treatment. Fifthly, an irritable bladder is more often a nerve symptom than a uterine one. Sixthly, in a large number of cases of supposed or of actual uterine disease which display marked gastric disturbance, if the tongue be clean, the essential disease will be found to be neurotic, and it must be treated so. Seventhly, almost every supposed uterine case characterized by excess of sensibility and by scantiness of will power is essentially a neurosis. Eighthly, in the vast majority of cases in which the woman takes to her bed, and stays there indefinitely from some supposed uterine lesion, she is bedridden from her brain and not from her womb. I will go further, and assert that this will be the rule even when the womb itself is displaced or is disordered by a disease or by a lesion that is not in itself exacting or dangerous to life. Ninthly, groin aches and sore ovaries are far more commonly symptoms of exhaustion than of diseases of the appendages. Finally, uterine symptoms are not always present in cases of uterine disease.

Playfair, from his enormous personal experience, concludes: “1. The removal of the adnexa is not justifiable in cases of pure functional neurosis. 2. Even when appreciable disease of the tubes and ovaries is present, an operation should not be performed until palliative treatment has first been tried. The results in hysterolepsy and hystero-mania are so uncertain that celiotomy is not to be advised.”—*Journal of Obstetrics*, October, 1893.

THE PUERPERIUM.—*Tender nipples.* It is within the first few days that the mother experiences the most severe discomfort with tender nipples. They should be carefully washed with warm water, both before and after nursing, and then dried with a soft towel. If they become tender, it is well at this time, to make an application of some substance which will be both emollient and protective. The difficulty usually experienced with such substances is the necessity of removing them before the child is applied, and this is of itself oftentimes sufficient to cause irritation.

A very efficient preparation, which possesses the desired qualities, and which it is not necessary to remove, is a mixture of equal parts of olive oil and subnitrate of bismuth. The preparation dries on the nipple, leaving a coat which is slightly astringent, impervious to air, unharmed to the child and prophylactic against fissures.—Rodgers, *American Gynecological Journal*; 1893.

DANGERS AND COMPLICATIONS OF UTERINE FIBROIDS.—Conclusions by Dr. Gordon, *Journal of Obstetrics*: 1. Uterine fibroids are always more or less troublesome, and in a large majority of cases produce a state of chronic invalidism.

2. In a large percentage of cases they are complicated with excessive hæmorrhages, peritonitis, salpingitis, and ovaritis, with purulent collections and adhesions, producing continual suffering.

3. Many of them do not cease growing at the menopause, but increase.

4. Many undergo degeneration, either calcareous, cystic, or malignant.

5. Hysterectomy is not a very dangerous operation if made in the early history of the case—no more so than ovariectomy.

6. In addition to the saving life, it relieves (in nearly all the cases) the woman from a life of invalidism.

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY
CHAS. M. THOMAS, M.D.

LARYNGITIS HIEMALIS.—Dr. J. C. Mulhall, of St. Louis, describes a simple variety of subacute laryngitis, in which the secretions are, *ab initio*, adhesive crusts, mechanically producing dysphonia, more often complete aphonia, and occurring *alone during winter*. He has adopted the term "winter" laryngitis, because he has never seen the disease except in winter.

The crusts adhere more closely to the true than to the false cords; cling with great tenacity to the inter-arytænoid fold, and are often found on the under surface of the true cords. The disease may be acute and last but two or three weeks, but may readily, without appropriate treatment, last the entire winter.

One not familiar with this clinical picture—for it is rare—might suggest that this is a variety of the well-known "laryngitis sicca." The latter is, however, nearly always associated with pharyngitis sicca, or rhinitis atrophica, being *sequential* to these conditions. It is essentially a chronic disease, the secretions often foetid, and is modified by climatic conditons.

Hygiene, both in the cure and the prophylaxis, is of most importance in the treatment. Let the patient wear light woollen undergarments, thick-soled shoes without rubbers, and avoid overheated apartments. He should sleep in a cold room, sponge in cold water, maintain silence in the open air, avoid stimulants, etc. Locally, a spray of vaseline and eucalyptol, ten minims to the ounce is of most service. The cold, wet pack at night is of service.—*N. Y. Med. Journal*, Oct. 14, 1893.

A MEANS OF RELIEF IN HAY FEVER.—Ferber, of Hamburg, reports his own case of hay fever which had been so severe as to necessitate his using a closed carriage all through the summer. His relief was brought about from accidentally noticing that in the winter a coryza was usually accompanied with hot ears which regained their normal temperature when the discharge from the nose was established. He determined to try a reversed order of effect on the hay fever in the summer, and began accordingly to rub his ears until they became red and hot.

It is now the third year that he has been able to lead an endurable existence during the hay fever season. "As soon as the least sensation of fulness in the nose appears, there is recognized a certain amount of pallor in the ears. A thorough rubbing of the ears, at times even to contusion, has always succeeded in freeing the nasal mucous membrane from its congestion. The rubbing, however, must be *thorough* and repeated as often as the least symptom of congestion returns to the nose. Since using this treatment I have been able to take long sandy walks, sit and even sleep with open windows or pass an evening in my garden without distress. Several patients have had the same relief from this treatment, always in proportion to the thoroughness of the rubbing, and I hope by this means some other physician may be able to give his patients the same great relief."—*Boston Medical and Surgical Journal*.

TUMOR OF THE OPTIC THALMUS.—Wharton Sinkler, M.D., Philadelphia, reports a case of this kind in the *University Medical Magazine*, October, 1893. The patient, aged 46 years, had always enjoyed excellent health. In January, 1893, she became sleepy and drowsy; her myopia increased, but she had no pain in eyes or head; she complained of dim distant vision, but the correction of her error gave normal sight. Her slowness of speech increased, and in April there was slight aphasia. The fundus, during her entire illness, was normal, as was also the field. The next symptom noticed was paresis of the right side of the face; her hands seemed unable to guide themselves, the inco-ordination being greater in the right than in the left. In April pain in the head developed, at times intense. There was now marked paresis of the right side of the face; sensation was impaired on the right side of the face, but was not lost. In attempting to walk she staggered considerably. The knee-jerks were exaggerated but there was no ankle clonus. The urine was normal. The temperature was normal, or subnormal, at times as low as 97°, and the pulse slow, varying from 56 to 70 beats in the minute. There was at no time any convulsive movements, either local or general. The above symptoms became aggravated and death occurred. The autopsy showed the left optic thalamus to be as large as a hen's egg, the enlargement extending in all directions and involving the posterior part of the corpus striatum. The surface was smooth and covered with numerous large vessels. The consistency was firm and elastic.

MONTHLY RETROSPECT OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D., AND FRANK H. PRITCHARD, M.D.

TREATMENT OF ECZEMA.—Dr. J. P. Tessier has long made a study of this cutaneous affection, and in presenting the treatment divides it into the internal and external. Internally the remedies are, alphabetically, as follows:

Carbolic Acid.—Generalized eczema, with ectropion of the eyelids, especially in the dry and squamous forms.

Picric Acid.—Eczema, with severe itching, especially at night, and but slight oozing. No clinical confirmations.

Anacardium Orientale.—Generalized eczema, with severe pruritus, especially of the head and face.

Arsenicum.—Chronic eczema, with thickened and indurated skin, with burning and itching. Higher dilutions best.

Cantharis.—Eczema rubrum, and above all, in acute cases. Internally and externally; a few drops of the M. T. in 200 grammes (6½ ounces) of water, for lotions and compresses.

Chamomilla.—Intertrigo eczema of infants, during dentition.

Chelidonium Majus.—Rebellious eczema of the scrotum.

Chininum Sulphuricum.—Acute eczema, with intermittent pruritus. From the third to the sixth decimal dilution. Red and oozing erythema, with intolerable itching; swelling of the skin.

Chloral.—Eczema of the face, and especially of the free borders of the eyelids, with intense pruritus. A few grains of the crude drug in 200 grammes (6½ ounces) of water.

Croton Tiglium.—Eczema of the face and genitals. Relieves the associated itching of eczema with remarkable rapidity.

Euphorbium.—Has a certain and manifest influence on the pruritus.

Graphites.—An excellent remedy. Impetiginous eczema, of long duration, rhagades, abnormal and faulty growth of the nails. He cured an eczema of the backs of the hands of several years' duration with a salve of 50 cgms. (8 grs.) of the first dec. trit. in 20 gms. (5 drachms) of vaseline. Internally, it has given him good results in 6x to 12x.

Mercurius.—Internally it is disappointing, while externally it is active. Use salves of the white, yellow, or red precipitates, with caution and prudence, in chronic eczema of slight extent. It is often rapidly efficacious.

Mezereum.—A precious remedy in eczematiform dermatitis, intense pruritus.

Petroleum.—Great sensitiveness of the skin; every lesion tends to ulcerate; itching; excoriated and weeping eczema; rhagades. Often employed by him with success. He cured with it a case of eczema of the backs of the hands in fifteen days, which had been under the treatment of several specialists.

Rhus Toxicodendron and Rhus Vernix.—Of service in eczematous affections, especially acute. *Rhus vernix* is useful in eczema rubrum, in massive doses.

Sepia.—Eczema marginatum. Brownish, reddish, or squamous spots on the skin; desquamation in the form of a ring. Of great service when indicated by the general symptoms.

Sulphur.—Rarely indicated, though intercurrently it will augment the action of other remedies.

External Treatment.—Diet of great importance. Avoid sea-fish, shell-fish, pork, "high" game, fermented cheeses, etc.

Acute Eczema.—Dust on frequently and profusely powdered starch. If the in-

inflammation be very intense, apply a starch poultice, prepared with a solution of boric acid, in a thin layer of fine muslin. Renew when cold. Make a new one every three to four hours. In less intense cases an envelopment with muslin, impregnated with some emollient water, as a decoction of starch or bran in boric acid water, and covered with a thin cloth, will be found of benefit. In intense and grave cases an application of lime water and oil will be of service. Salves will often cure an eczema that will not respond to internal treatment. The danger of repercussion of exanthems is greatly exaggerated. In eczema of gouty or dartrous origin do not use topical applications of any strength. The mildest application which is useful when the skin is very irritable is: vaseline, 20 gms., ℥v.; oxide of zincone, gram, grs. xv. If insufficient after a few applications, use vaseline, 20 gms., ℥v.; oxide of zinc, boric acid, ana, 1 gm. (grs. xv.). These salves are anodyne, but if the eczema remain rebellious then prescribe salicylic acid, chrysophanic acid, ana, 5 dgms., grs. viij., boric acid, 1 gm., grs. xv., and vaseline, 40 gms., ℥j½. Only use this salve in eczemas of ancient date, without inflammatory reaction and with desquamation resembling psoriasis. In some cases mercurial salves are best applied and in minimal doses: red precipitate, 2 dgms., grs. iij.; vaseline, 20 gms., ℥v.; or, vaseline, 20 gms., ℥v.; white precipitate, 4 dgms., grs. vj. Unna praises: pyrogallie acid, 10 gms., ℥ijss.; salicylic acid, 3 gms., grs. xlv.; ichthyol, 15 gms., ℥iv.; vaseline, 100 gms., ℥iijss. This is a strong salve, and if not well borne apply resorcine, ichthyol, ana, 5 gms., ℥j½; salicylic acid, 2 gms., grs. xxx.; simple unguent, 100 gms., ℥iijss. Apply the salves in the evening after washing the affected spot with a borated or naphtholated soap. Morning and evening wash the skin with water which has been boiled and allowed to cool somewhat, and to which has been added a little vinegar or eau de cologne if the skin is greasy or oily, or a little tincture of benzoin or glycerine if it be dry or cracked; then dust with Venetian talc, 40 gms., ℥jss.; salicylic acid, 25 cgms., grs. iv.; calomel, 5 dgms., grs. viij.; powdered boric acid, 75 dgms., grs. x.; powdered camphor, 20 gms., ℥v. Triturate well. — *L'Art Médical*, No. 9, 1893.

A CASE OF CANNABIS INDICA POISONING.—Dr. F. Windscheid, of Leipsic, records a case of poisoning of extract of cannabis indica in a friend. He took, in two hours, in broken doses, three grammes, forty-five grains, of the solid extract of the drug in the afternoon, the last at six. No symptoms until 8.30 P.M., when his watcher noticed that he suddenly broke off the conversation, reached towards the objects about him, and said: "How peculiar; a strange power is overcoming me." Nearly immediately after, complaints of a feeling of anxiety, a raging stage of excitement set in. Together with a few pessimistic ideas, with transient bodily relaxation, there was excessive motor restlessness, and a continuous running hither and thither, with violent, lively gestures and uninterrupted talking. The very well-read and highly cultivated prover declaimed wildly and confusedly the most difficult selections from the classics, and, contrary to his usual habit, with many errors, in that he changed words of his own accord. Now and then, ideas of grandeur prevailed; he was a millionaire, a Russian prince, all men were his subjects, etc. Inclination to reflections, the patient explaining everything that he did, and why this and that was obliged to be said. No sensations of flying, as on other recorded poisonings. Towards ten o'clock he suddenly became quieter, after an hour and a half of the most extravagant delirium, saying, "I think it is at an end." He then became apathetic, complained of intolerable burning in his mouth and great thirst, terrific palpitation of the heart and anxiety, with a feeling as though "he must die," so that his friend-watcher became anxious and sent for Dr. W. He found him conscious, lying with eyes closed and a sensation as though an electric current continually swept through his body. Pupils widely dilated, reacting slowly to light. Slight hyperæsthesia of the hands, very sensitive to the least noise or light. Reflexes unaltered. Continual twitchings, especially of the upper extremities, now and then spreading over the entire body. Pulse small, regular and 172(!). Heart normal. The night passed very restlessly, with delirium and attempts to jump up. The next morning quieter, increased sensitiveness and augmented skin reflexes; slightly touching the leg with a needle caused nearly convulsive twitching of the whole body; the patellar reflexes greatly increased. The patient continued to improve, though for a day or so there was apathy, absence of will-power, a tendency to theatrical attitudes and to sentimentality, which latter lasted for days. At first, he could hardly be forced to leave his bed for a few minutes, which apathy was in contrast with his usual habits. — *Wiener Medizinische Presse*, No. 21, 1893.

TUBERCULOUS MENINGITIS.—Dr. Kroener observed a case of meningitis, of apparently tuberculous origin, in a fifteen-months' old child, who had developed distinct symptoms of scrofulosis after vaccination. He found the child with moderate fever, pulse 100-110, soft and yielding, now and then dirotic; appetite bad for several days, increasing weakness and exhaustion; child took no interest in surroundings: now and then, vomiting; temperature, one and one-half to two degrees above the normal; at night, it often cried out suddenly. She took no interest in her playthings; sudden noises did not attract her attention, and often she made aimless motions with her hands. Pupils unequally dilated, reflex pupillary rigidity, and finally, the pulse was intermittent. Sulph. 6x and apis 3x were given, every two hours, in alternation; the former on account of the scrofulous habitus, and the apis as indicated in tuberculous meningitis—after Farrington. Cold-water compression to the head. This condition remained thus for six to seven days, though the pupillary difference was gone the next day. In a week, the child began to awaken, for a few minutes, out of its soporous condition and resisted the daily examination; commenced to have interest in its surroundings. The thirtieth dilution was substituted, for experiment, but with a slight relapse and aggravation. Steady improvement, the intelligence returned, hearing being the last to recur, it reacted to sudden noises near its ears by reflex closure of the eyelids. It began to sit up and play without aid, and the pulse became more regular; it was able to stand by holding on to a chair, etc. In two months from beginning of treatment it was completely well, though in walking it was somewhat unsteady. It also had an eczema of the scalp, which dried up at the outbreak of the meningitis. A friend cured a very similar case by apis.—*Zeitschrift des Berliner Vereines Homöopathischer Aerzte*, Bd. xii., Heft v.

ALCOHOLIC PARALYSIS.—Dr. Mosca, of Stuttgart, calls attention to alcoholic paralysis as described in Charcot's Lectures on Diseases of the Nervous System. It is especially frequent in females, from the use of liquors, essences, etc., which contain alcohol. The patient has horrible dreams, nightmare, terrible visions, disturbances of sensation in the lower extremities, especially prickling sensations, formication, stitches and "lightning-like" pains which run through the extremity. They appear pre-eminently at night, so that the patients look to the coming of night with terror, for during sleep they are tortured with horrible dreams and hallucinations, and when awake the pains are very severe. Hyperæsthesia of the skin generally accompanies the pains, and later extends to the upper limbs. Later, analgesia of the skin follows, so that neither heat, cold, pricks of a pin, nor contact with the floor is felt. Then paralysis sets in, affecting chiefly the flexors. The feet hang flaccid with the toe downwards, the toe cannot be raised, the reflex tendons are absent. The muscles of the trunk may be attacked, those of the face never. They feel flabby, and electric excitability is reduced. The peripheral nerves and their terminations are only affected. The skin may present vaso-motor disturbances—a reddish or violet coloration; œdema around the ankles (without albuminuria or diabetes). In other patients sweat may suddenly break out on the hands or feet, or alternate with vaso-motor changes; redness and paleness. It may be confounded at first with tabes dorsalis or diabetes. Lead paralysis is also to be thought of. Unfortunately the diabetic and the one with lead poison is often alcoholic. Therapeutically he recommends hydrotherapy, abstinence and tonics. Homœopathically, besides the antidotes to alcohol, nux vomica, stramonium and veratrum, arsenic, sulphur, and lead are of service. [Arsenicum seems to have an affinity for the nerves of the lower extremity, while plumbum affects, primarily, those of the upper—hence this sign is held to be of value in the differential diagnosis of arsenical paralysis.—Eds.]—*Allgemeine Homöopathische Zeitung*, Nos. 9 and 10, 1893.

CUPRUM IN OBSTINATE VOMITING.—Dr. Baldelli, of Florence, Italy, was consulted by a lady of 27 years, who had suffered for over a year from obstinate vomiting. As soon as she had eaten or drank anything she felt a sense of weight and malaise in the stomach, and general restlessness, which increased until she would be obliged to vomit, after which she felt well. Besides the ingesta, the vomited matter contained filaments of mucus like the white of an egg. Only milk agreed with her, and even that finally had to be abandoned. A dose of nux vom. gave some relief. He discovered that she was in the habit of eating sweets in large quantities, and guided by this indication, he administered cuprum, with a complete disappearance of the vomiting in a few days. Her appetite returned, and without observing any special diet, she feels well.—*Rivista Omeopatica*, No. 8, anno xxxviii.

POISONING BY PRIMULA OBCONICA.—Dr. C. Kingsley Ackland reports the following case: About eighteen months ago I was consulted by a lady for repeated attacks of an intensely irritable papular eruption on both hands. The eruption lasted three or four days, then desquamated. On one occasion the chin was affected. My patient was an enthusiastic gardener, and had a considerable knowledge of plants. She suspected the *primula obconica* from having read of its peculiar properties, and, in order to put her suspicions to the test, bared her arm and lightly passed a bunch of its leaves round the middle of the forearm. Nothing happened until the next day, more than twelve hours after the experiment, when a broad band of small papules appeared on a raised base, giving rise to almost intolerable itching. She found that it was not necessary for the juice of the leaves to be applied to the skin, and also that if the fingers, after handling the plant, touched the face, the eruption was produced there as well. A strange feature was that there were no effects produced until after the lapse of so many hours. The flowers alone had no evil influence. For several months before the cause of the trouble was discovered, this patient's life was almost unendurable from the terrible irritation. After getting rid of all of this particular kind of *primula*, there was no further attack.—*Lancet*.

DROSENA ROTUNDIFOLIA.—In the *Leipziger Populäre Zeitschrift fuer Homöopathie* a résumé is given of this plant. Hahnemann regarded it as one of the most active remedies, and of especial value in whooping-cough, cough with pain in the hypochondria, as though this region were constricted. This same pain prevents cough, and it is only possible when the hand is held at the præcordium, cough coming deep from the chest, contraction of the abdominal muscles, spasm of the fingers. The present (German) homœopaths do not regard it of much value in pertussis. *Belladonna*, in the first stage, and *cuprum aceticum* in the convulsive stage, are mostly employed. Rather in chronic gastro-bronchitis, in elderly persons with a chronic catarrh of the bronchi and organs of digestion, would it be indicated. The patient is either without appetite, having a sensation of pressure and fulness after eating, with tympanites; or, in another case, the chest symptoms will be more prominent, with a chronic tracheal and bronchial catarrh, associated with a sense of suffocation and an inclination to take a long breath. Such patients alternate in their symptoms between the thorax and abdomen. They complain, with the cough, of a feeling in the hypochondria as if something had been "dislocated."

TREATMENT OF LEPROSY.—Drs. P. and M. Jousset, of Paris, give arsenicum the first place. *Hydrocotyle Asiatica* has been praised, though they cannot say that it has given them any results. *Hydrastis*, in the mother-tincture, internally and externally, proved of signal benefit in a leprous patient, in the second stage. For the nervous form of the disease they advance:

Arsenicum.—3x to 6x. Muscular atrophy, vesicles filled with blood, at the ends of the fingers ulcers, ulcers and crusts under the nails.

Phosphorus.—12x to 6x. Formication in the extremities, anæsthesiæ, ulcers which do not cicatrize near the nails.

Plumbum.—30x to 6x. Muscular atrophy, backs of hands bluish, pasty and infiltrated, vesicles and gangrene.

Secale Cornutum.—6x to M. T. Anæsthesia and numbness of the extremities, upper, with a tendency to gangrene. Dr. Zembaco Pascha, who has made a profound study of lepra, recommends, chiefly, arsenicum and ergot.—*L'Art Médical*, No. 9, 1893.

LAC CANINUM IN DIPHTHERIA.—Either tonsil may be attacked, more frequently the left, with sensation of painful lump in the throat. A characteristic objective symptom, is the transposition of the inflammation, or membranous deposit, from one side to the other. In some cases warm drinks, in others cold, are most agreeable to the throat; empty swallowing most painful; solids more painful than liquids (*lach.* has more pain from swallowing liquids than solids); tongue coated white with red edges, white coated, dark or leaden-hued at the centre and root, heavily white coated, dirty coated, moist or dry. Sometimes difficult articulation and stammering when attempting to talk fast; speech accompanied by rattling of mucus along the tongue. The subject will drink little and often, or has salivation and drooling from the mouth. External throat very sensitive; sensation as if the throat were closing, dry and hot feeling in the throat as if scalded; constant inclina-

tion to swallow which is both difficult and painful. Uvula and tonsils swollen, of a light pink or red color, and shining appearance. Uvula elongated, and with the swollen tonsils, cedematous, having a diphtheritic coat; breath offensive, putrid; speech nasal; pricking pains in tonsils shooting up to ears; throat feels stiff as a board (*sepia*); tickling sensation and constriction in upper throat causing a dry hacking cough; membrane in throat varies from a white to a gray or black.—*N. A. Journal of Homœopathy*, October, 1893.

AMMONIUM MURIATICUM IN CORYZA.—Itching in the nose and frequent sneezing with crawling in the throat. Ulcerative pain in nostril; nose very sore to touch; loss of smell; one nostril stopped up during the day, both stopped up at night. Clear water running from the nose and corroding the lips; acrid, scalding discharge. Sensation of coldness between the shoulders; throbbing in the tonsils. Hoarseness, with burning in the region of the larynx. Dry, hacking cough at night.—*Ibid.*

NATRUM MURIATICUM IN CORYZA.—Sneezing worse when undressing at night or when rising in the morning. Nose sore and interior of it swollen; fever blisters; squirming in right nostril as of a small worm. Discharge of clear mucus, alternating with stoppage of the nose. Hoarseness and dry tickling cough; weakness; sad; sensation of sand in the eyes; catarrh of frontal sinuses, with neuralgic pains.—*Ibid.*

SANGUINARIA IN CORYZA.—Much sneezing; rawness of the Schneiderian membrane, with loss of sense of smell; dull heavy pains over the root of nose and stinging sensation in the nose; coryza particularly of the right nostril; polypi; copious, acrid, burning, watery discharge. Throat dry with hacking cough; worse lying down; headache with nausea and chilliness, then flushes of heat.—*Ibid.*

RESPIRATORY SYMPTOMS OF AMMONIUM CARBONICUM.—Stoppage of nose, mostly at night; must breathe through mouth. Starts up at night from sleep all stopped up, feels as though could not breathe, with rattling or wheezing in chest on breathing or coughing. Nose is dry, or if there is any discharge it is scanty, hot and acrid. Cough is dry, very violent, and worse from 3 to 4 A.M., with a sensation as of a feather in the throat.—*Ibid.*

KALI CARB. IN RESPIRATORY AFFECTIONS.—The symptoms of the nose under this drug are less prominent than either *ammon. c.* or *calc. c.*, but its action on the throat is more marked. There is much tenacious mucus, hawking, and clearing the throat, worse in morning, and sharp, sticking pains in the throat.

In the chest there are many sharp, sticking, and cutting pains. "Cutting pains in evening in chest after lying down;" "sticking in chest on inspiration;" "sore pains in chest (similar to *calc. c.*)."

The cough is dry and expectoration difficult on account of adhesive character of secretion, but when once detached it may fly quickly from the mouth, not adhering all the way out, as in *kali bi.* Cough is worse from 3 to 4 A.M.; also worse by lying down and better sitting up. May be spasmodic, with gagging and vomiting.—*Ibid.*

SOME CHARACTERISTICS.—If patient has head always turned to one side, *cina*; if patient sleeps with the knees apart, *cham.*, and *platina* if occasioned by extreme genital soreness. If patient sleeps with legs stretched out to full length, *puls.* and *rhus*; if patients bend their heads forward, *staphisagria*, and if backward, *hyoscyamus*; if patients lie with hands on the belly, *puls.*; if patient sleeps with one leg drawn up and the other stretched out, *stannum*; if patient dreads to go to bed because bones will then feel as if loaded down with lead, *lachesis*; if patient has enlarged pupils, think of *bell.*, if contracted, *opium*; if patient has one pupil larger than the other, *gelse*; if patient has phthisis, there will be retraction of the corners of the mouth in the last stages. If patient gags or vomits at the thought of food, *colchicum*; if patient has hot pale cheek, and a cold red cheek, *moschus*; if patient in confinement "cusses" you, spits in your face, and pulls your whisker, *cham.*; if patient is a baby, sleeping all day and crying all night, *lycop.*; if patient has cracking in ears when riding or talking loud, *aloes*; if when eating, *nitric acid.*—Dr. Frank Kraft, *Am. Hom.*

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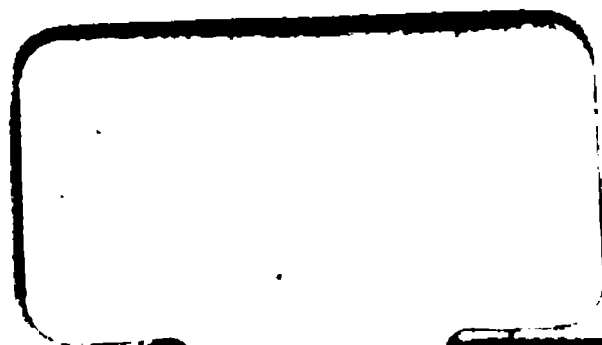
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